NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)149

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	8 August 2024
Director Lead	Lee Bond – Group Chief Financial Officer
Contact Officer / Author	Lee Bond Sally Stevenson – Assistant Director of Finance – Compliance and Counter Fraud
Title of Report	**Group Scheme of Delegation and Powers Reserved for the Trust Board – Draft for Approval**
Executive Summary	The existing Scheme of Delegation and Powers Reserved for the Trust Board (SoD) for Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) and Hull University Teaching Hospitals NHS Trust (HUTH) were initially reviewed and aligned, with a separate SoD document produced for each Trust. These draft documents were circulated to the Group Executive Cabinet for its meeting on 28 May 2024, following which it was agreed to produce one combined SoD document for NHS Humber Health Partnership (the Group). Comments received from Executive Directors were duly reviewed and incorporated as appropriate. The resulting combined Group SoD document was then circulated to the Audit, Risk and Governance Committees-in-Common (ARG CiC) Non-Executive Directors (NEDs), Trust Chair and Trust Vice Chairs and Group Director of Assurance on 1 July 2024. Comments received were once again duly reviewed and incorporated as appropriate. The draft SoD document was then received and endorsed at the meeting of the ARG CiC on 25 July 2024, prior to submission to the Trust Boards-in-Common. **The Trust Boards-in-Common are asked to consider and approve the draft Group Scheme of Delegation and Powers Reserved for the Trust Board.**
Background Information and/or Supporting Document(s) (if applicable)	Existing Scheme of Delegation and Powers Reserved for the Trust Board for each Trust.
Prior Approval Process	As set out above.
Financial Implication(s)	N/A
Implications for equality, diversity and inclusion, including health inequalities	N/A
Recommended action(s) required	✓ Approval ☐ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Chief Executive's Office

GROUP

(NHS HUMBER HEALTH PARTNERSHIP)

SCHEME OF DELEGATION AND POWERS RESERVED FOR THE TRUST BOARD

Reference:	
Version:	
This version issued:	
Result of last review:	
Date approved by owner (if applicable):	
Date approved:	
Approving body:	Audit, Risk and Governance Committees-in-Common / Group Trust Board
Date for review:	
Owner:	
Document type:	Miscellaneous
Number of pages:	23 (including front sheet)
Author / Contact:	Lee Bond, Group Chief Financial Officer

Contents

1.0 Introduction

1.1 **Northern Lincolnshire and Goole NHS Foundation Trust** (hereafter referred to as 'NLAG') achieved Foundation Trust status on 1st May 2007 following approval by the Independent Regulator at that time (Monitor). **Hull University Teaching Hospitals NHS Trust** (hereafter referred to as 'HUTH') is a statutory body which came into existence on 1 October 1999, with the organisation formally changing its name to incorporate its Teaching Trust status on 1 March 2019.

1.2 In 2023 the two Trusts agreed to form a Group operating model with a single harmonised Executive team and leadership structure. Whilst both organisations retain their individual sovereignty, there is aligned corporate governance and decision making across the Group. This means that as much decision making as is practicable will take place via a 'committees-in-common' (CiC) approach for both the Trust Boards and its Board sub-committees. Further details are set out in the Board and Committees-in-Common Principles Framework (DCP427). In addition, there is a Group Memorandum of Understanding which sets out the framework through which both Trusts have a shared commitment to working more closely together.

1.3 The Group name is **NHS Humber Health Partnership** (hereafter referred to as 'the Group').

1.4 This document is designed to describe how the Group operates i.e., how it is structured, how it takes decisions, and where authority and accountability is held.

1.5 This Scheme of Delegation and Powers Reserved for the Trust Board (hereafter referred to as the 'Scheme of Delegation') applies to the Group unless expressly stated otherwise throughout, to account for any variations between NHS Foundation Trust status (NLAG) and NHS Trust status (HUTH).

1.6 All references within this document to Trust Board Executive positions, such as the Chief Executive and the Chief Financial Officer relate to their Group Executive titles i.e., Group Chief Executive and Group Chief Financial Officer.

1.7 For effective governance the Trust Board must have in place arrangements to ensure that there is clarity about how and where decisions are made, and who makes them. The Code of Governance for NHS Provider Trusts requires that the Trust Board:

- Clearly identifies the types of decision which are to be reserved for the Council of Governors (NLAG only) and the Trust Board, and;
- Ensures that arrangements are in place to enable responsibility for other decisions to be clearly delegated to executive management.

1.8 The Trust Board has a responsibility to ensure that staff at all levels of both organisations confidently understand what delegated authority they have to make decisions, and are clear what to do when they do not have authority. The Scheme of Delegation sets out who has the authority to make decisions within the Group.

1.9 This document cannot be read in isolation, it sits alongside other documents to create a governance framework for the Group. Critical documents linked to the Group Scheme of Delegation are the Trust Constitution (NLAG), Standing Orders (SO's) (HUTH), Group Standing Financial Instructions (SFI's), the Performance Management Framework, and the Standards of Business Conduct Policy (NLAG) /

Declaring Gifts and External Interests Policy (HUTH). All such documents are freely available to all staff on the Group intranet site.

1.10 Each Trust's Directorates and Care Groups are not independent, they are part of the Trust / Group. They are granted powers through the Scheme of Delegation to allow them to manage themselves effectively to organise and deliver high quality services. However, they will be expected to use the authority delegated to them in the best interests of the Group and its patients.

2.0 Underpinning Principles of Empowerment

2.1 The Scheme of Delegation has been designed to be a tool to empower Executive Directors, and those managers who have been given authority to act on their Executive Directors' behalf through the respective Directorate or Care Group Scheme of Delegation, to take appropriate action within a robust corporate framework.

2.2 Directorates and Care Groups will have defined freedoms under the Scheme of Delegation, but will remain bound to the Group's Vision and Values, strategies, policies and procedures. Any Directorate or Care Group decision taken under the freedoms set out in the Scheme of Delegation remains subordinate to Trust Board decisions. Responsibility for appropriate implementation, and ensuring appropriate compliance, rests with the Directorates and Care Groups which make up the Group.

2.3 Directorates and Care Groups are not legal entities in their own right, but are part of the corporate whole that is the NHS Foundation Trust (NLAG) / NHS Trust (HUTH). Participation in and compliance with each Trust's strategies, policies and procedures is mandatory.

2.4 Whilst the Scheme of Delegation provides the power to commit resources to individual Directorates and Care Groups, Directorates and Care Groups must recognise the decisions of the Trust Board in the allocation of resources.

2.5 The Trust Board's strategies, policies and procedures also shape the expectation of the employer regarding the behaviour of employees. Employees will comply with instructions issued by the Trust Board, or set out the Scheme of Delegation, or in other corporate governance or policy documents.

2.6 Where either Trust is subject to independent review and inspection (e.g., Care Quality Commission (CQC), NHS England (NHSE), External Audit, Health and Safety Executive (HSE), etc.) the relevant Trust will co-ordinate the organisation's preparation for assessment and the action plan following assessment. Directorates and Care Groups must support and co-operate with these initiatives as they apply to their areas of responsibility within the Group.

2.7 Corporate Directorates will manage a range of services where it is judged by the Trust Board that this represents the most appropriate course of action. Other Directorates and Care Groups do not have the prerogative to establish their own services in these areas, and must make use of corporate services. Where required, Directorates and Care Groups will identify staff who will co-ordinate these arrangements at local level, and work with the central teams to ensure that each Trust, and the Group as a whole, discharges its responsibilities effectively.

2.8 The Scheme of Delegation is also based on a key principle that all leases and buildings are owned by the respective Trust, and any users of that space, do so as a

"tenant" of the Trust concerned. The Chief Financial Officer acts as the "landlord" on behalf of each Trust, and has control over which users occupy which space.

2.9 The Trust Board will retain the option to authorise corporate intervention to support a Directorate or Care Group. In certain circumstances, it may also be necessary to set aside the usual devolution arrangements, using this authority, in order to manage specific issues and problems. This will be agreed by the Trust Chief Executive on behalf of the Trust Board.

2.10 Any decision to suspend the agreed devolution arrangements for either Trust will be reported to the Trust Board by the Trust Chief Executive , along with an explanation of the rationale for doing so. The Performance Management Framework provides the rules and processes for such action. The Chief Executive may choose to intervene outside the formal Performance Management Framework, according to individual circumstances, subject to the oversight of the Trust Board.

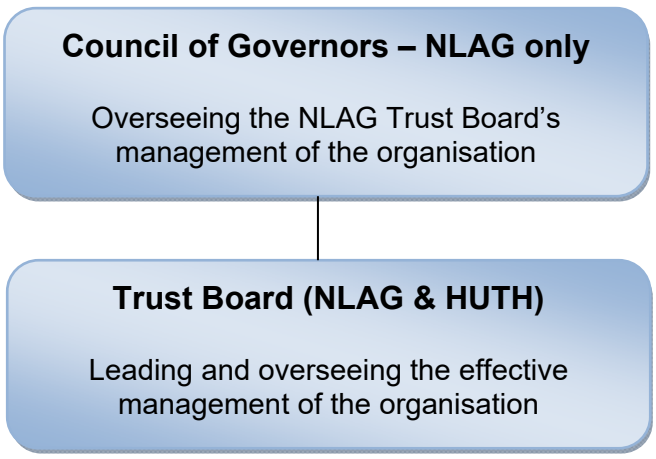
2.11 In order to ensure that responsibility is clearly delegated within individual Directorates and Care Groups, individual Directorate and Care Group Schemes of Delegation will be adopted which are appropriate to their particular circumstances and management structures in line with the overarching Scheme of Delegation at Appendix A.

2.12 Each Executive Director remains accountable for compliance with all strategies, policies and procedures in their Directorate or Care Group, and must take all appropriate steps to ensure that their staff are aware of the necessary details to carry out their duties.

2.13 Each Executive Director must take corrective action when issues of non-compliance occur in their Directorate or Care Group, including escalation of the issue where this is necessary.

3.0 The Council of Governors (NLAG) and the Trust Board

3.1 As a NHS Foundation Trust, NLAG is constituted with two principal bodies charged with overseeing the running of the organisation namely the Council of Governors and the Trust Board, whereas HUTH as a NHS Trust does not have a Council of Governors:



3.2 **The NLAG Council of Governors:** The NLAG Council of Governors represent the interests of local communities, partners and staff in the development of NLAG, and forms the link between the Executive Directors of the organisation (the NLAG Trust Board), and the NLAG members – i.e. the staff, patients and public of the organisation who have formally become members. The NLAG Council of Governors hold the Trust Board to account on behalf of the members.

3.3 **The NLAG Governors:** The NLAG Council of Governors is composed of a mix of elected and appointed members, and includes a Lead Governor, representing the following groups:

- The public in the various localities served by the Trust (NLAG);
- The staff of the Trust (NLAG);
- Stakeholder organisations.

The detailed composition of the NLAG Council of Governors is set out in the Trust Constitution. The Chair of the Trust is also the Chair of the NLAG Council of Governors.

3.4 **Purpose of the Council of Governors:** The primary role of the Council of Governors is to hold the NLAG Non-Executive Directors individually and collectively to account for the performance of the Board of Directors and to represent the interests of the members of the Trust as a whole and the interests of the public.

3.5 **Powers of the Governors:** The NLAG Council of Governors have specific powers reserved for them in the NLAG Constitution by which they exercise their control over the Trust Board. The key powers are:

- Appointing both the Chair and Non-Executive Directors to the NLAG Trust Board;
- Appointing NLAG's External Auditors (with the advice of the NLAG Audit, Risk and Governance Committee);
- Agreeing to refer the NLAG Trust Board to the Regulator (currently NHS England) where they believe that the Trust Board is failing to exercise its duties effectively.

3.6 The Council of Governors therefore has restricted but important powers – by the control over critical oversight and governance functions, and through the power of referral to the Regulator, the Council of Governors forms a crucial part of NLAG's governance system. Further details of the operation and structure of the Council of Governors can be found in the NLAG Trust Constitution.

3.7 **The Trust Board:** The Trust Board is the principal accountable body for each Trust. It is responsible for ensuring that the Group has clear and coherent strategic objectives, to benefit the public and other stakeholders, is effectively managed in pursuit of those strategic objectives, and that appropriate governance safeguards are in place to protect the interests of patients, staff and the taxpayer. The Trust Board consists of the Chair, Chief Executive, Executive Directors and Non-Executive Directors.

3.8 **Trust Chair:** Appointed by the Council of Governors (NLAG) / Secretary of State for Health (HUTH), the Trust Chair, in addition to performing the duties of a Non-

Executive Director, is responsible for the effective running of the Board, and ensuring that the Board is able to properly coordinate the activities of each Trust / the Group.

3.9 **Vice Chair:** One of the Non-Executive Directors will also be nominated as Vice Chair, primarily to perform the duties of the Chair in his or her absence.

3.10 **Senior Independent Director:** One of the Non-Executive Directors will be appointed as Senior Independent Director. This role is established primarily to take an independent view where there are significant disagreements within the Trust Board.

3.11 **Non-Executive Directors:** Non-Executive Directors are appointed by the Council of Governors (NLAG) and in accordance with the NHS Trusts (Membership and Procedure) Regulations (HUTH). Non-Executive Directors are selected to bring a range of differing skills and experience to the Trust Board, and effectively scrutinise the work of the Trust Executive Directors in performing their duties, through the various assurance Committees of the Trust Board and through more general review of the activities of the Trust / Group.

3.12 **Chief Executive:** The Chief Executive is the Accountable Officer (HUTH) and Accounting Officer (NLAG) of the Trust, ultimately responsible for the economical, efficient and effective running of the organisation. This includes overall responsibility for management of resources across the organisation.

3.13 **Executive Directors:** The Board also includes the Executive Directors of the Trust / Group. Executive Directors do not all have voting rights within the Trust Board, and those who do not vote are marked with an asterisk (*) on the list below:

- Group Chief Medical Officer
- Group Chief Nursing Officer
- Group Chief Financial Officer
- Group Chief Delivery Officer
- Group Chief People Officer *
- Group Chief Strategy and Partnerships Officer*
- Group Director of Assurance*

3.14 **The Unitary Board:** The Trust Board is designed as a Unitary Board with decisions to be reached by discussion and consensus, with all Executive and Non-Executive Directors permitted to participate in all discussions. All members of the Trust Board are bound collectively to the decisions taken by the Board. Further details of the working of the Trust Board can be found in the Trust Constitution (NLAG) or Standing Orders (HUTH).

4.0 Management Structures and Performance Management

4.1 The Trust is currently organised into Directorates and Care Groups, which form the basic operating units of the Group, and the foundation for the Scheme of Delegation.

4.2 Each Directorate / Care Group is accountable to the Chief Executive, and through him/her to the Board, for:

- Delivering agreed plans and objectives;
- Managing a delegated budget within the terms of the Scheme of Delegation and the SFIs, and;
- Complying with the Group's vision and values, strategies, policies and procedures established and approved by the Trust Board.

4.3 **Executive Directors:** Executive Directors are ultimately responsible for ensuring that their Directorates / Care Groups remain compliant and deliver against their plans and budget.

4.4 **Directorate / Care Group Schemes of Delegation:** Each Executive Director is responsible for ensuring that their Directorate / Care Group has in place an appropriate Scheme of Delegation which is in line with the levels of authority set out in this overarching document, making clear who has the authority to make decisions and commit resources. This Scheme of Delegation must be compliant with corporate policies, and must be kept up to date. This is a key control document for each Directorate / Care Group, and therefore the Group.

4.5 **Performance Management Framework:** The Group sets out in its Performance Management Framework the principles to be used in scrutinising Directorates and Care Groups concerning their operational, quality and financial performance. This includes the measures available to the Trust Board in withdrawing delegated authority from an Executive Director, in whole or in part, and the grounds on which such action might be taken.

5.0 Powers Retained by the Board

5.1 Code of Accountability of the Trust Board

5.1.1 The Code of Accountability, which has been adopted by the Trusts, requires the Board to determine which decision making powers it retains at Trust Board level, and does not delegate. These reserved matters are set out in paragraphs 5.2 to 5.10 below, and in effect constitute the core duties of the Trust Board.

5.2 General Enabling Provisions

5.2.1 The Board may determine any matter it wishes in full session within its statutory powers, and conditions of the Trust's Provider Licence.

5.2.2 Equally, the Board may choose, in full session within its statutory powers and conditions of the Trust's Provider Licence, to specifically delegate responsibility for any of its reserved powers, having fully defined the terms of such delegation.

5.3 Regulation and Control:

5.3.1 Approval of the Trust Constitution (NLAG) and Standing Orders (SOs), a schedule of matters reserved to the Board, and Standing Financial Instructions (SFIs) for the regulation of its proceedings and business.

5.3.2 Suspend, vary or amend Standing Orders.

5.3.3 Approval of a Scheme of Delegation of powers from the Board to officers.

5.3.4 Requiring and receiving the declaration of Directors' interests which may conflict with those of the relevant Trust or the Group, and determining the extent to which that Director may remain involved with the matter under consideration.

5.3.5 Disciplining Executive Directors who are in breach of statutory requirements of SOs or SFIs.

5.3.6 Approval of the disciplinary procedure for employees of the Trust / Group.

5.3.7 Approval of arrangements for dealing with complaints.

5.3.8 Adoption of or substantial modification to the structures and procedures used by the Trust / Group to carry out its operations.

5.3.9 Receiving reports from its sub-committees, including those that each Trust is required to establish, and to take appropriate action in response to issues raised by those committees.

5.3.10 Confirming the recommendations of any of the Trust's committees, where the committee does not have delegated executive powers.

5.3.11 Establishing terms of reference and reporting arrangements of the formal sub-committees of the Trust Board.

5.3.12 Noting / ratifying of any urgent business decisions taken by the Chair and/or Chief Executive.

5.3.13 Approval of arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for Charitable Funds.

5.3.14 Authorise use of the Trust seal by either Trust.

5.4 Appointments:

5.4.1 Appoint the Senior Independent Director.

5.4.2 Appoint, discipline and dismiss Executive Directors.

5.4.3 The creation and dissolution of formal sub-committees of the Trust Board.

5.4.4 The appointment of members of any sub-committee of the Trust Board.

5.5 Arrangements for Discharging Statutory Responsibilities:

5.5.1 Approving management responsibilities, arrangements and policies which relate to the fulfilment of a statutory function.

5.6 Strategy, Business Plans and Budgets:

5.6.1 Defining the strategic and operational aims and objectives of each Trust / the Group.

5.6.2 Each year, approving a Trust Plan which is submitted to the Independent Regulator for each Trust within the Group which includes:

- assumptions on service delivery and requirements;
- contract and associated income assumptions;
- expenditure plans and associated assumptions;
- savings plans on revenue;
- capital expenditure programmes;
- plans for managing working capital and cash; and
- any non-revenue financing arrangements, such as loans.

5.6.3 Overall approval of programmes of investment.

5.6.4 Approve the Group's organisational development proposals (People Strategy).

5.6.5 Approve outline and final business cases for capital investment in line with the scheme of delegation.

5.6.6 Approve proposals for new areas of business to each Trust amounting to £5million or more.

5.6.7 Approve arrangements in relation to spin off companies.

5.6.8 Approve applications for loans.

5.6.9 Approval of Performance Management Policy.

5.6.10 Approval of Investment Policy.

5.7 Direct Operational Decisions:

5.7.1 Acquisition and disposal of land and/or buildings.

5.7.2 Approve PFI proposals.

5.7.3 The introduction or discontinuance of any significant activity or operation. An activity or operation shall be regarded as significant in line with the financial limit set out in the Scheme of Delegation at Appendix A.

5.7.4 Approval of individual contracts (other than NHS contracts) of a capital or revenue nature in line with the financial limits set out in the Scheme of Delegation at Appendix A.

5.7.5 Approval of individual losses, write offs and compensation payments in line with the Group SFI's.

5.7.6 Agreeing action on litigation not covered by CNST or RPST against or on behalf of each Trust.

5.7.7 Approval of acquiring or granting new leases in line with the Group SFI's.

5.8 Financial and Performance Reporting Arrangements:

5.8.1 Continuous appraisal of the affairs of each Trust in the Group by means of receipt of reports, as specified by the Trust Board, from Executive Directors, Committees and officers of the Trust. All monitoring returns required by the Independent Regulator and the Charity Commission shall be reported, at least in summary, to the Trust Board.

5.8.2 Approval of the opening or closing of any bank or investment account.

5.8.3 Consideration and approval of each Trust's annual report, including the annual financial accounts and quality accounts.

5.8.4 As Corporate Trustee, receipt and approval of the annual report for Charitable Funds.

5.8.5 Receipt of the minutes of the Performance, Estates and Finance Committee meetings, taking appropriate action in the light of recommendations emanating from it.

5.9 Audit Arrangements:

5.9.1 Approval of internal audit arrangements (including arrangements for the separate audit of Charitable Funds where necessary).

5.9.2 Receipt of the minutes of the Audit, Risk and Governance Committee meetings, and take appropriate action.

5.9.3 Receipt of the annual management letter received from the external auditor, and agreement of action on any recommendations, where appropriate, from the Audit, Risk and Governance Committee.

5.9.4 Receipt of the annual report including the Annual Governance Statement and Head of Internal Audit Opinion received from the internal auditor, and the agreement of action on the any recommendations, where appropriate, from the Audit, Risk and Governance Committee.

5.9.5 Ensuring appropriate support arrangements are in place to enable the NLAG Council of Governors to carry out its duties in appointing and continued engagement of the External Auditor. Approval of external audit arrangements (including for the separate audit of Charitable Funds) following a recommendation from the Auditor Panel (HUTH).

5.10 Risk Monitoring and Management:

5.10.1 Approval and monitoring of the Group's policies and procedures for the management of risk.

6.0 Scheme of Delegation of Powers from the Board

6.1 Role of the Chief Executive

6.1.1 All powers of each Trust within the Group which have not been retained as reserved by the Board or delegated to an Executive Committee or Trust Board sub-committee shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall prepare a Group Scheme of Delegation identifying which functions they shall perform personally and which functions have been delegated to other Executive Directors and officers.

6.1.2 All powers delegated by the Chief Executive can be re-assumed should the need arise. The Chief Executive is the Accountable Officer (HUTH) and Accounting Officer (NLAG).

6.2 Caution over the Use of Delegated Powers

6.2.1 Powers are delegated to Executive Directors and officers on the understanding that they will not exercise delegated powers in a manner which is likely to be a cause for public concern, or that are not in the best interests of the Trust / Group overall.

6.3 Directors' Ability to Delegate their own Delegated Powers

6.3.1 The Group Scheme of Delegation shows only the overview of delegation within the Trusts / Group. The Scheme of Delegation is to be used in conjunction with the systems of budgetary control and other established procedures within the Directorates and Care Groups of each Trust / Group. The Scheme of Delegation (Appendix A) sets out the limits applicable to Executive Directors in delegating their authority.

6.4 Absence of Director or Officer to Whom Powers have been Delegated

6.4.1 In the absence of an Executive Director or officer to whom powers have been delegated, those powers shall be exercised by that Executive Director or officer's

superior, unless there is a designated deputy or interim post holder, or appropriate alternative arrangements have been approved by the Chief Executive.

6.5 Executive Committees and Trust Board Sub-Committees

6.5.1 The Board may determine that certain of its powers shall be exercised by Executive Committees or Board sub-committees. The composition and terms of reference of such committees shall be that determined and approved by the Board from time to time, taking into account where necessary the requirements of the Independent Regulator and/or the Charity Commissioners (including the need to appoint an Audit Committee and a Remuneration Committee).

6.5.2 The Board shall determine the responsibility, scope and reporting requirements in respect of all Executive Committees or Trust Board sub-committees. Committees may not delegate executive powers to other subsidiary committees unless expressly authorised by the Board.

6.6 Delegation from Directors to Officers

6.6.1 Each Director is responsible for the delegation within their Directorate or Care Group, and should produce a Scheme of Delegation to this effect which is in line with the levels of authority set out in this document.

6.6.2 Care Group and Directorate Schemes of Delegation must include clear accountability and delegation arrangements for budget management, and procedures for approval of expenditure.

7.0 Levels of Delegated Authority within the Scheme of Delegation

7.1 **Authority Levels:** Each Trust in the Group operates a simplified range of authority levels (Appendix A), which are used to construct Directorate and Care Group Schemes of Delegation. The aims of the levels are to provide clarity of authority, and to enable effective management decision making at the most appropriate level, supporting the smooth running of each organisation / the Group.

7.2 **Effective Controls:** The authorisation levels are also designed to limit the numbers of staff able to unilaterally commit resources, in line with NHS England's best practice requirements. This has to be balanced against allowing each organisation / the Group to effectively carry out its operations.

7.3 **Compliance with SOs and SFIs:** Authorisation levels do not exempt any officer of either Trust from maintaining compliance with the Trust's Constitution (NLAG), Standing Orders, or Standing Financial Instructions.

7.4 **Levels of Authority:**

Chief Executive: **Accountable / Accounting Officer and Prime Budget Holder**	The Trust Board delegates budgetary responsibility to the Chief Executive, as the **Prime Budget Holder**. The Chief Executive in turn delegates to Executive Directors.
Executive Directors: **Directorate and Care Group Budget Holders**	**Directorate and Care Group Budget Holders** are accountable for the budget and use of resources delegated to them. They must also ensure that an appropriate scheme of delegation is in place to cover their area of delegated authority which is in line with the levels of authority set out in this document.
Senior Managers: **Budget Managers**	**Budget Managers** have delegated powers in line with the Directorate or Care Group scheme of delegation, and are accountable for management decision making and use of resources in the area over which they have delegated authority.
Managers and Supervisors: **Authorised Signatories**	**Authorised Signatories** are managers and supervisors authorised to sign off expenditure within budgets in line with agreed policies and procedures.

7.5 Specific authority and powers at each level are set out in the following sections, which look at principal areas of management decision making and control.

8.0 Agreeing Contracts for Trust / Group Services

8.1 **Delegation to Lead Executive Director:** The Chief Executive, on behalf of the Trust Board, delegates to the Chief Financial Officer and the Chief Delivery Officer (with advice from the Chief Medical Director and Chief Nurse on issues of quality and safety as necessary) responsibility for negotiating contracts for its services with commissioners. The Chief Financial Officer is responsible for reporting regularly to the Trust Board on progress in negotiating contracts, and on monitoring and delivery against contracts in year. Such contracts will be formally signed by the Chief Executive on behalf of the Trust Board, based on the recommendation of the Chief Financial Officer and Chief Delivery Officer.

8.2 **Contracting Objectives:** Contracts should be agreed in accordance with prevailing NHS rules and guidelines, and should be constructed to support service development plans agreed by the wider community.

8.3 **Performance and Quality Parameters within Contracts:** Contracts should reflect the service objectives agreed and signed off by the Trust Board as part of the business planning process, subject to the constraints arising from contract negotiation with Commissioners.

8.4 **Financial Parameters within Contracts:** Contracts should align with the financial parameters agreed by the Trust Board as part of its annual business planning process, subject to the constraints of negotiations with Commissioners.

8.5 **Powers and Duties:**

Trust Board: **Governing Body**	The **Trust Board** oversees the business planning process, and signs off the financial plan within which contracts should be set.
Chief Executive: **Accountable / Accounting Officer**	The **Chief Executive** delegates the Chief Financial Officer and Chief Delivery Officer to negotiate contracts for Trust services with Commissioners. The Chief Executive will formally sign off such contracts on behalf of the Trust Board, based on the recommendation of the Chief Financial Officer and Chief Delivery Officer.
Chief Financial Officer and Chief Delivery Officer: **Lead Executive Directors**	The **Chief Financial Officer and Chief Delivery Officer** are responsible for negotiating contracts with Commissioners on behalf of the Trust, in line with agreed service plans and financial plans, and making recommendations to the Chief Executive.
Executive Directors: **Directorate and Care Group Budget Holders**	**Executive Directors** are responsible for supporting the contracting process, and delivery of contracting and income objectives through their Directorate and Care Group plans.

9.0 Managing Pay Expenditure and Staffing Costs

9.1 **Delegation of Budget to Divisional/Directorate Budget Holders:** The Trust Board agrees the financial plan and budget for each planning period, usually the coming financial year, before the commencement of the period for each Trust. This budget will include a proposed allocation for the Chief Executive to delegate to the Directorate and Care Group Budget Holders (Executive Directors).

9.2 **Budgeting for Pay:** Divisional and Care Group Budget Holders will decide the allocation of their budget between pay and non-pay. They may change this in year through virements. Divisional and Care Group Budget Holders remain accountable for overall budget management, and delivery against other service and performance objectives.

9.3 **Delegation:** Executive Directors may delegate budgets as they deem appropriate to best empower their team and deliver effective control.

9.4 **Powers:** Powers available to each level of delegated authority, and powers held by the Trust Board's Executive Committees, are set out below:

Remuneration Committee: **Executive Committee**	The **Remuneration Committee** is delegated with: • Setting Executive Director and other VSM remuneration; • Approving Interim engagements above financial thresholds set by the Regulator; • Approving Interim engagements where pay rates exceed Regulator guidance; • Approving redundancy, early retirement payments or special severance payments in line with Appendix A of the Group Scheme of Delegation and subject to approval by the Independent Regulator / HM Treasury; • Approving arrangements for additional payments for performance or clinical excellence; • Approving arrangements for additional payments for recruitment or retention. • Approve pay or other terms and conditions outside nationally set contracts; • Approve pay rates for non-substantive engagements, including bank rates and extra contractual duty rates.
Group Executive Cabinet: **Executive Committee**	The **Group Executive Cabinet** will: • Make recommendations to the Remuneration Committee on pay or other terms and conditions outside nationally set contracts; • Make recommendations to the Remuneration Committee on pay rates for non-substantive engagements, including bank rates and extra contractual duty rates.
Chief Executive: Accountable/ Accounting Officer and Prime Budget Holder	The **Chief Executive as Accountable Officer** delegates the pay budget, and: • Approves any control measures which limit the powers of Director/Divisional Budget Holders, or their Budget Managers.

Executive Directors: **Directorate and Care Group Budget Holders**	**Directorate and Care Group Budget Holders** have the power to: • Agree establishments and changes to establishments within their funded budget allocation with the approval of the Chief Financial Officer and the Chief People Officer, in line with Appendix A of the Scheme of Delegation; • Agree upgrades or incremental progression within their budget, in line with Corporate policies and with the approval of the Chief People Officer, in line with Appendix A of the Group Scheme of Delegation; • In addition, they may exercise any powers available to their delegated budget managers and authorised signatories.
Senior Managers: **Budget Managers**	**Budget Managers** have delegated powers to: • Adjust establishments within their existing delegated budget; • Recruit to posts within their budgeted establishment; • Authorise payroll data forms affecting pay, new starters, change forms and termination forms, for staff working within their delegated area of responsibility (in line with their Directorate/Care Group SoD); • In addition, budget managers may exercise any powers held by authorised signatories for the budgets within their area of responsibility.
Managers and Supervisors: **Authorised Signatories**	**Authorised Signatories** are empowered to: • Authorise timesheets and electronic shift records (in line with their Directorate/Care Group SoD); • Authorise travel claims and subsistence expenses within agreed policies and procedures (in line with their Directorate/Care Group SoD).

9.5 All staff are bound to all Trust / Group policies and procedures when exercising any of these powers.

9.6 Where Executive Directors delegate budgetary control, financial delegation will be subject to confirmation that those staff have the necessary skills and competencies relevant to the scale and complexity of the budget responsibility delegated to them. Financial training and support will be arranged where necessary and compliance with this training is required.

10.0 Managing Non-Pay Expenditure and Commitments

10.1 **Delegation of Budget to Divisional/Directorate Budget Holders:** The Trust Board agrees the financial plan and budget for each planning period, usually the coming financial year, before the commencement of the period. This budget will include a proposed allocation for the Chief Executive to delegate to the Directorate and Care Group Budget Holders (Executive Directors).

10.2 **Budgeting for Non-Pay:** Divisional and Care Group Budget Holders will decide the allocation of their budget between pay and non-pay. They may change this in year through virements. Divisional and Care Group Budget Holders remain accountable for overall budget management, and delivery against other service and performance objectives.

10.3 **Delegation:** Executive Directors may delegate budgets as they deem appropriate to best empower their team and deliver effective control.

10.4 **Powers:** Powers available to each level of delegated authority, and powers held by the Trust Board's Executive Committees, are set out below:

Trust Board: **Governing Body**	The **Trust Board** retains authority to: • Agree contracts in line with financial limits set out in the Group Scheme of Delegation at Appendix A; • Agree instigation of legal action in contract disputes outside standard procedures.
Chief Executive or Chief Financial Officer: **Authorising Executives**	The **Authorising Executives** may authorise expenditure commitments above Executive Director limits, to ensure appropriate compliance: • Approve expenditure in line with financial limits set out in the Group Scheme of Delegation at Appendix A.
Executive Directors: **Directorate and Care Group Budget Holders**	**Executive Directorate and Care Group Budget Holders** have the power to: • Approve expenditure in line with financial limits set out in the Group Scheme of Delegation at Appendix A; • In addition, they may exercise any powers available to their delegated budget managers and authorised signatories.
Senior Managers: **Budget Managers**	**Budget Managers** have delegated powers to: • Approve expenditure in line with financial limits set out in the Group Scheme of Delegation at Appendix A; • In addition, budget managers may exercise any powers held by authorised signatories for the budgets within their area of responsibility.
Managers and Supervisors: **Authorised Signatories**	**Authorised Signatories** are empowered to: • Authorise orders through standard contract systems with agreed frameworks and prices, in line with financial limits set out in the Group Scheme of Delegation at Appendix A;

All staff are bound to all Trust / Group policies and procedures when exercising any of these powers. Refer also to sections 2.9 and 2.10 of this document.

10.5 Where Executive Directors delegate budgetary control, financial delegation will be subject to confirmation that those staff have the necessary skills and competencies relevant to the scale and complexity of the budget responsibility delegated to them. Financial training and support will be arranged where necessary and compliance with this training is required.

11.0 Managing Tenders, Quotations and Contracts

11.1 Regulatory Framework Governing Tendering and Awarding Contracts for Services and Supplies: Each Trust is required and detailed by law to ensure that competition for the use of public funds is open, fair and free from bribery and nepotism. Therefore before any commitment is made to incur expenditure, the appropriate procurement procedure must be followed, in line with the requirements relating to tendering and contracting procedures contained within the Group SFIs.

11.2 Powers: Powers available to each level of delegated authority, and powers held by the Trust Board's Executive Committees, are set out below:

Trust Board: **Governing Body**	The **Trust Board** retains authority to: • Set SFIs relating to contracts, procurement and tendering; • Approve individual contracts in line with financial limits set out in the Group Scheme of Delegation at Appendix A.
Chief Executive and Chief Financial Officer: **Authorising Executives**	The **Authorising Executives** must both: • Authorise contract commitments above Executive Director limits, to ensure appropriate compliance, in line with financial limits set out in the Group Scheme of Delegation at Appendix A.
Executive Directors: **Directorate and Care Group Budget Holders**	**Directorate and Care Group Budget Holders** have the power to: • Ensure that all tenders and contract awards are compliant with The Procurement Act and other regulatory requirements, in liaison with the Procurement Department; • Ensure that tenders and quotations are obtained in line with the requirements / financial limits set out in the Group Scheme of Delegation at Appendix A. • Ensure that Waivers are submitted and approved for all instances where the above SFI requirements cannot be met.

11.3 Waiving SFI Requirements: In exceptional circumstances it may be impractical to follow the above process. If so a request for Waiver of Standing Financial Instructions (relating to quotations and tenders) must be completed and signed by the relevant Executive Director, before being submitted to the Director of Procurement for review / approval or recommendation to the Chief Financial Officer (depending on value), who must authorise the waiver in line with the Trust's Waiver Procedure. In the absence of either the Director of Procurement or Chief Financial Officer, and the need for urgency, the Chief Executive shall perform the authorisation function. In the absence of both the Chief Financial Officer and Chief Executive refer to the Waiver Procedure for instructions on how to proceed. Expenditure should only be committed once a waiver of SFIs has been approved.

11.4 All staff are bound to all applicable Trust / Group policies and procedures when exercising any of these powers. Refer also to sections 2.9 and 2.10 of this document.

11.5 Each Care Group and Directorate is bound to maintain appropriate input to the Trust / Group Contract Register, which maintains a comprehensive listing of the Trust's / Group contractual commitments. This will allow appropriate Procurement support to contract renewal or re-tendering processes.

11.6 Responsibility for compliance with the Group's SFIs resides solely with the relevant Executive Director for their area. However, every member of staff has a responsibility to comply with the Group SFIs.

12.0 Managing Capital Expenditure

12.1 **Regulatory Framework Capital Expenditure:** The Trust Board is responsible for agreeing the capital programme as part of the financial plan. The responsibility for managing the capital programme is delegated to the Capital and Major Contracts Committee.

12.2 **Powers:** Powers held by the Trust Board's Executive Committees, are set out below:

Trust Board: **Governing Body**	The **Trust Board** will: • Approve an annual capital programme as part of the annual budget; • Ensure that the capital programme is in line with the Trust's strategic priorities; • Ensure that the capital programme is within the Trust's capital limits set by Regulators; • Agree variation to the total capital allocation, or variation to individual elements of the capital programme exceeding in line with financial limits set out in the Scheme of Delegation at Appendix A.
Capital and Major Projects Committee: **Executive Committee**	The **Capital and Major Projects Committee** is empowered to: • Review and manage the capital programme in line with the limits delegated by the Trust Board, as set out in the Scheme of Delegation at Appendix A; • Agree capital programme changes within the scope of the overall programme limits, and in line with financial limits set out in the Scheme of Delegation at Appendix A. • Ensure regular reporting to the Trust Board on delivery progress on the capital programme.
Group Capital Committee: **Working Group**	The **Group Capital Committee** is empowered to: • Prepare, prioritise, monitor and implement the Trust's capital investment programme. • Authorise variations to schemes up to a certain financial value, as set out in the Scheme of Delegation at Appendix A; • Recommend schemes over a certain financial value to Capital and Major Projects Committee / Trust Board.

12.3 **Capital Programme Governance:** The Capital and Major Projects Committee is responsible for ensuring that the Trust Board remains appropriately informed on progress in delivering the capital programme, and any changes made to the programme within its delegated limits. This extends to ensuring that appropriate project management groups and monitoring arrangements are in place for the whole capital programme.

12.4 All staff are bound to all applicable Trust policies and procedures when exercising any of these powers. Refer also to sections 2.9 and 2.10 of this document.

Appendix A

Appendix A is a spreadsheet document and can therefore be found at the following link –

Scheme of Delegation Appendix A (DCM077A)

	AUTHORITY DELEGATED TO: *(Note: a tick followed by an asterisk indicates that both delegated officers are required to give authority)*	Trust Board	Group Executive Cabinet	Remuneration Committee	Performance, Estates & Finance Committee	Capital & Major Projects Committee	Group Capital Committee	Group Chief Executive Officer	Group Chief Financial Officer	Group Chief Delivery Officer	Group Chief Medical Officer	Group Chief Nurse	Group Chief People Officer	Group Chief Strategy & Partnerships Officer	Group Director of Assurance	Group Chief Digital Information Officer (reporting to CMO)	Group Director of Estates (reporting to CFO)	Director of Procurement (reporting to CFO)	Site (North & South) Triumvirate Members	Care Group Triumvirate Members	Delegated Budget Manager	Authorised Signatory
1	**BUSINESS PLANNING, BUDGET SETTING, AND MONITORING**																					
2	Agreeing Annual Financial Plan (including budgetary allocations, savings and efficiency targets)	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
3	Agreeing Performance Management Framework	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
4	Monitoring of Budgetary Performance	✓	✓	-	✓	✓	✓	✓	✓	-	-	-	-	-	-	-	-	-	✓	-	-	-
5	Agreeing Performance Management Action	✓	✓	-	-	-	-	✓	-	✓	-	-	-	-	-	-	-	-	✓	-	-	-
6	**SETTING CONTRACTS FEES AND CHARGES FOR TRUST HEALTHCARE SERVICES**																					
7	Pricing and Agreement of NHS Contracts with Commissioners	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
8	Approving Service Contracts as part of the Financial Plan	-	✓	-	-	-	-	✓	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
9	External Fees - Private Patients & Overseas Visitors	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
10	External Fees (Income generation and other patient related services)	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
11	Fees for Items of a Sensitive Nature	-	-	-	-	-	-	✓	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
12	**MANAGEMENT OF REVENUE BUDGETS - COMPLIANCE WITH BUDGETARY ALLOCATION LIMITS**																					
13	For the totality of the Trust	-	-	-	-	-	-	✓	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
14	At Care Group / Divisional level	-	-	-	-	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	-	-
15	At individual cost centre budget level	-	-	-	-	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-
16	For all central income budgets	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
17	For all centralised budgets not otherwise allocated to a Director	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
18	Removing or suspending delegated authority	✓	-	-	-	-	-	✓	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
19	**TRANSFERS BETWEEN BUDGETS**																					
20	Transfers between Director allocations	-	-	-	-	-	-	✓	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
21	Transfers of budgets between Care Groups	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
22	Transfers of budgets within areas of responsibility (Directors make proposals to CFO)	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
23	Utilisation of budget allocation under-spends	-	-	-	-	-	-	✓*	✓*	-	-	-	-	-	-	-	-	-	-	-	-	-
24	**PERSONNEL AND PAY**																					
25	Setting Executive Director, Director and other VSM Remuneration	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
26	Approving interim engagements over £50k total cost (financial threshold set by Regulator guidance)	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
27	Approving interim engagements where pay rates exceed Regulator guidance	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
28	Approving redundancy, early retirement payments or special severance payments - all staff - less than £25k (subect to approval by the Independent Regulator / HM Treasury - in line with HM Treaury's 'Managing Public Money')	-	-	-	-	-	-	✓*	✓*	-	-	-	-	-	-	-	-	-	-	-	-	-
29	Approving redundancy, early retirement payments or special severance payments - all staff - above than £25k (subect to approval by the Independent Regulator / HM Treasury - in line with HM Treaury's 'Managing Public Money')	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
30	Approving arrangements for additional payments for performance or excellence	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
31	Approving arrangements for additional payments for recruitment and retention	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
32	Approving pay or other terms and conditions outside nationally set contracts	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
33	Approving pay rates for non substantive engagements including bank and extra contractual duty rates	-	-	-	-	-	-	✓	✓	✓	-	-	✓	-	-	-	-	-	-	-	-	-
34	Authority to book clinical / non-clinical agency staff (in line with area's SoD) Out of hours this will be the on-call Executive	-	-	-	-	-	-	✓	✓	✓	✓	✓	✓	✓	✓	-	-	✓	✓	✓	✓	-
35	Authority to agree upgrades or incremental progression (via AFC Banding Panel process)	-	-	-	-	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-
36	Authority to authorise overtime, time off in lieu, or other exceptional items	-	-	-	-	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
37	Authority to complete payroll data forms affecting pay, new starters, variations & leavers (in line with area's SoD)	-	-	-	-	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-
38	Authority to authorise time sheets and electronic shift records	-	-	-	-	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
39	Authority to authorise travel and subsistence expenditure	-	-	-	-	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
40	**AUTHORITY TO OBTAIN QUOTATIONS, AND TENDERS / WAIVING SFIs FOR QUOTATIONS AND TENDERS**																					
41	£0 to £25,000 total value (excl. VAT) - Quotations to be obtained by the budget holder from a sufficient number* of firms/individuals to provide fair and adequate competition as appropriate to ensure value for money. *sufficient number will vary depending on industry/type of goods being procured but must evidence value for money.	-	-	-	-	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
42	£25,001 to £75,000 total value (excl. VAT) - obtain formal quotations from a sufficient number of firms/individuals to provide fair and adequate competition as appropriate to ensure value for money.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	✓	-	-	-	-
43	Between £75,001 (excl.VAT) and the appropriate procurement threshold (including VAT) - undertake a local tender exercise with the opportunity published in line with Procurement Regulation.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	✓	-	-	-	-
44	Over the appropriate procurement threshold (including VAT) - formal procurement exercise with the opportunity published in line with Procurement Regulation.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	✓	-	-	-	-
45	Approval for waiving SFIs for quotations and tenders (Director of Procurement - Quoatation waivers up to £75k; Tender Waivers up to Procurement Threshold / CFO - Procurement Threshold to £500k / Group Executive Cabinet - £500k to £2.5m / Trust Board - Above £2.5m)	-	-	-	-	-	-	✓	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
46	**AUTHORITY TO AWARD AND SIGN CONTRACTS (SEE ALSO NHS SERVICE CONTRACTS ABOVE)**																					
47	Authorisation of single contracts (including variation and extension) for revenue or capital £3 - £5m total value (excl. VAT)			-	✓	✓		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
48	Authorisation of single contracts (including variation and extension) for revenue or capital £1.5m - £3m total value (excl. VAT)	-	-	-	-	-	-	✓*	✓*	-	-	-	-	-	-	-	-	-	-	-	-	-
49	Authorisation of single contracts (including variation and extension) for revenue up to £1.5m total value (excl. VAT)	-	-	-	-	-	-	✓	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
50	Authorisation of single contracts (including variation and extension) for capital up to £1.5m total value (excl. VAT)			-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
51	Authorisation of single contracts (including variation and extension) for revenue or capital up to the Procurement Threshold (inc. VAT)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	✓	-	-	-	-
52	**AUTHORISATION LIMITS - REQUISITIONS**																					
53	Authorisation of requisitions up to £5k (excl. VAT) - Budget holders	-	-	-	-	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
54	Authorisation of requisitions up to £25k (excl. VAT)	-	-	-	-	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-
55	Authorisation of requisitions up to £50k (excl. VAT)	-	-	-	-	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	-
56	Authorisation of requisitions up to £100k (excl. VAT)	-	-	-	-	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	-	-
57	Authorisation of requisitions up to £500k (excl. VAT)	-	-	-	-	-	-	✓	✓	-	-	-	-	-	-	-	-	✓	-	-	-	-
58	Authorisation of requisitions £500k to £1m (excl. VAT)	-	-	-	-	-	-	✓	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
59	Authorisation of requisitions over £1m to 3m (excl. VAT)	-	-	-	-	-	-	✓*	✓*	-	-	-	-	-	-	-	-	-	-	-	-	-
60	Authorisation of requisitions £3m to £5m (excl. VAT)	-	-	-	✓	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
61	Authorisation of requisitions over £5m (excl. VAT)	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
62	Carbon Trading with values over £100k	-	-	-	-	-	-	✓*	✓*	-	-	-	-	-	-	-	-	-	-	-	-	-
63	Carbon Trading with values up to £100k	-	-	-	-	-	-	-	✓*	-	-	-	-	-	-	-	✓*	-	-	-	-	-
64	Authorisation of new category items / authorisers on the no Purchase Order (PO) approved exceptions list maintained by Finance (e.g. utilities, NHS Supply Chain, NHS Resolution invoices, etc.)	-	-	-	-	-	-	✓	✓	-	-	-	-	-	-	-	-	-	-	-	-	-

		AUTHORITY DELEGATED TO: *(Note: a tick followed by an asterisk indicates that both delegated officers are required to give authority)*																				
		Trust Board	Group Executive Cabinet	Remuneration Committee	Performance, Estates & Finance Committee	Capital & Major Projects Committee	Group Capital Committee	Group Chief Executive Officer	Group Chief Financial Officer	Group Chief Delivery Officer	Group Chief Medical Officer	Group Chief Nurse	Group Chief People Officer	Group Chief Strategy & Partnerships Officer	Group Director of Assurance	Group Chief Digital Information Officer (reporting to CMO)	Group Director of Estates (reporting to CFO)	Director of Procurement (reporting to CFO)	Site (North & South) Triumvirate Members	Care Group Triumvirate Members	Delegated Budget Manager	Authorised Signatory
65	Authorisation of extraordinary non-pay expenditure items for which no budget exists.	-	-	-	-	-	-	✓*	✓*	-	-	-	-	-	-	-	-	-	-	-	-	-
66	Instigating legal action in any contractual dispute with a supplier	-	✓	-	-	-	-	✓	✓	-	-	-	-	-	-	-	-	✓	-	-	-	-
67	**APPROVAL OF REVENUE FUNDED BUSINESS CASES WITH MATERIAL STRATEGIC IMPACT - THRESHOLDS**																					
68	Recurrent revenue commitment - upto £2m per year	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
69	Recurrent revenue commitment - in excess of £2m per year	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
70	**CAPITAL SCHEMES**																					
71	Approving the annual capital programme	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
72	Approving variations to the total agreed annual capital programme (within agreed annual capital programme)	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
73	Approving variations on schemes, within the agreed capital programme, cost greater than £500k ex VAT	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
74	Approving variations on schemes, within the agreed capital programme, cost upto £500k ex VAT	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
75	Selection of architects, quantity surveyors, consultant engineers, and other professional advisors within EU regs	-	-	-	-	-	-	-	✓	-	-	-	-	✓	-	-	✓	-	-	-	-	-
76	**AGREEMENTS AND LICENCES**																					
77	Establishing, extending or terminating leases with annual rental over £500k	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
78	Establishing, extending or terminating leases with annual upto £500k	-	-	-	-	-	-	✓	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
79	Prep / signature of all tenancy agreements/licences for all staff subject to Trust policy on accommodation for staff	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	✓	-	-	-	-	-
80	Granting of use of Trust property under licence	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	✓	-	-	-	-	-
81	Loans, mortgages, guarantees and indemnities	-	-	-	-	-	-	✓*	✓*	-	-	-	-	-	-	-	-	-	-	-	-	-
82	**CONDEMNING AND DISPOSAL (obsolete, redundant, irreparable items (excluding land & buildings))**																					
83	Condemning plant and equipment with current/estimated value over £100k	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-
84	Condemning plant and equipment with current/estimated value up to £100k	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
85	Disposal of plant and equipment	-	-	-	-	-	-	-	✓*	-	-	-	-	-	-	-	✓*	-	-	-	-	-
86	**LOSSES, WRITE-OFFS AND COMPENSATIONS**																					
87	Losses (inc. cash) due to theft, fraud, overpayment and others - single items above £50k	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
88	Losses (inc. cash) due to theft, fraud, overpayment and others - single items £20k to £50k	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-
89	Losses (inc. cash) due to theft, fraud, overpayment and others - single items £5k to 20k	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
90	Losses (inc. cash) due to theft, fraud, overpayment and others - single items below £5k (DoF del to Asst DoF - P&C)	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
91	Fruitless payments (including abandoned capital schemes) - single items above £50k	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
92	Fruitless payments (including abandoned capital schemes) - single items £20k to £50k	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-
93	Fruitless payments (including abandoned capital schemes) - single items below £20k	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
94	All bad debts and claims abandoned, private patients, overseas visitors and other - single items above £50k	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
95	All bad debts and claims abandoned, private patients, overseas visitors and other - single items £20k to £50k	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-
96	All bad debts and claims abandoned, private patients, overseas visitors and other - single items below £20k	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
97	All bad debts and claims abandoned, private patients, overseas visitors and other - single items below £5k (DoF delegated to Asst DoF - Planning & Control)	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
98	Damage to buildings, fixtures & fittings and equipment - single items above £50k	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
99	Damage to buildings, fixtures & fittings and equipment - single items £20k to £50k	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-
100	Damage to buildings, fixtures & fittings and equipment - single items below £20k	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
101	Loss of equip & property in stores (e.g. fraud, theft, arson) or other - single items above £50k	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
102	Loss of equip & property in stores (e.g. fraud, theft, arson) or other - single items £20k to £50k	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-
103	Loss of equip & property in stores (e.g. fraud, theft, arson) or other - single items below £20k	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
104	Compensation payments made under legal obligation - single items above £50k	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
105	Compensation payments made under legal obligation - single items £20k to £50k	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-
106	Compensation payments made under legal obligation - single items below £20k	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
107	Extra contractual payments to contractors - single items above £50k	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
108	Extra contractual payments to contractors - single items £20k to £50k	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-
109	Extra contractual payments to contractors - single items below £20k	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
110	**EX-GRATIA PAYMENTS**																					
111	Staff and Patients for loss of personal effects - single items above £50k	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
112	Staff and Patients for loss of personal effects - single items £20k to £50k	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-
113	Staff and Patients for loss of personal effects - single items below £20k	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
114	Other - single items above £50k	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
115	Other - single items £20k to £50k	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-
116	Other - single items below £20k	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
117	**BANK ACCOUNTS / INVESTMENT OF FUNDS / BORROWING**																					
118	Approval of the opening or closing of any bank or investment account (based on recommendation from CFO)	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
119	Maintenance/Operation of Bank Accounts	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
120	Investment of Exchequer funds - in line with Treasury Management Policy	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
121	Investment of funds held on Trust (charitable funds) - Charitable Trustees	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
122	Use of borrowing as financing mechanism - normal revenue requirements	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
123	Use of borrowing as financing mechanism - special requirements (e.g. capital developments, add'l working capital)	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
124	**PETTY CASH DISBURSEMENTS (<u>other</u> than through central cashiers offices at each site)**																					
125	Expenditure up to £50 per item - petty cash holder	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
126	Expenditure over £50 to £250 per item	-	-	-	-	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	✓	✓	✓	-	-
127	Expenditure over £250 per item	-	-	-	-	-	-	✓	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
128	**APPROVAL OF INTRODUCTION OR DISCONTINUANCE OF SIGNFICANT ACTIVITY OR OPERATION**																					
129	Activity or operation shall be regarded as significant if gross annual income or expenditure is in excess of £2.5m	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
130	**AUTHORISATION OF INVESTMENT OF NEW EQUITY IN A SPIN OUT COMPANY**																					
131	Approval of creation of/participation in spin out companies and collaborative ventures	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
132	Approval of Trust withdrawal/cessation of spin out company, joint venture and collaborative venture	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
133	Approval of sale of spin out company, joint venture and collaborative venture	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
134	Investment in joint venture or other external structure	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
135	Delegated power to act as representative in collaborative venture once approved by the Trust Board	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-

		AUTHORITY DELEGATED TO:																				
		Trust Board	Group Executive Cabinet	Remuneration Committee	Performance, Estates & Finance Committee	Capital & Major Projects Committee	Group Capital Committee	Group Chief Executive Officer	Group Chief Financial Officer	Group Chief Delivery Officer	Group Chief Medical Officer	Group Chief Nurse	Group Chief People Officer	Group Chief Strategy & Partnerships Officer	Group Director of Assurance	Group Chief Digital Information Officer (reporting to CMO)	Group Director of Estates (reporting to CFO)	Director of Procurement (reporting to CFO)	Site (North & South) Triumvirate Members	Care Group Triumvirate Members	Delegated Budget Manager	Authorised Signatory
136	**INSURANCE POLICIES**																					
137	Medico-legal	-	-	-	-	-	-	-	-	-	✓*	-	-	-	✓*	-	-	-	-	-	-	-
138	All other insurance	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
139	**APPROVE AND MONITOR CONTRACTUAL ARRANGEMENTS BETWEEN THE TRUST AND OUTSIDE BODIES**																					
140	Provision of Clinical Services	-	-	-	-	-	-	✓	✓	-	-	-	-	-	-	-	-	✓	-	-	-	-
141	Provision of Other Services	-	-	-	-	-	-	✓	✓	-	-	-	-	-	-	-	-	✓	-	-	-	-
142	Property	-	-	-	-	-	-	✓	✓	-	-	-	-	-	-	-	✓	✓	-	-	-	-
143	**INTELLECTUAL PROPERTY (IP)**																					
144	Approval of licence agreements (See policy on Handling Inventions and Intellectual Property)	-	-	-	-	-	-	✓*	✓*	-	-	-	-	-	-	-	-	-	-	-	-	-
145	Approval of Material changes to IP policy (See policy on Handling Inventions and Intellectual Property)	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
146	**REPORTING OF INCIDENTS TO THE POLICE**																					
147	Fraud	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
148	Other	-	-	-	-	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	-	-	-
149	**GOVERNANCE / RISK MANAGEMENT**																					
150	Responsible for ensuring effective governance / risk management arrangements in place	✓	-	-	-	-	-	✓	-	-	-	-	-	-	✓	-	-	-	-	-	-	-
151	Responsible for ensuring policies / procedures & meeting structures are in place & provision of any advice	✓	-	-	-	-	-	✓	-	-	-	-	-	-	✓	-	-	-	-	-	-	-
152	Responsible for ensuring governance is 'owned by all'	✓	✓	-	-	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
153	**MANAGEMENT OF INCIDENTS / SIs, COMPLAINTS / CONCERNS AND CLAIMS**																					
154	Overall responsibility for sufficient systems and processes to report and respond to incidents / SIs	-	-	-	-	-	-	✓	-	-	-	✓	-	-	-	-	-	-	-	-	-	-
155	Responsibility for ensuring incidents/SIs are investigated thoroughly and in a timely manner	-	✓	-	-	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	-
156	Responsibility to ensure appropriate remedial action is taken / lessons learnt are shared for incidents/SI's	-	✓	-	-	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	-
157	Overall responsibility for ensuring that all complaints and concerns are dealt with effectively	-	-	-	-	-	-	✓	-	-	-	✓	-	-	-	-	-	-	-	-	-	-
158	Responsibility for ensuring complaints are investigated thoroughly and within agreed timescales	-	✓	-	-	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	-
159	Responsibility for ensuring appropriate remedial action is taken / lessons learnt are shared for complaints	-	✓	-	-	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	-
160	Responsibility for ensuring that claims are dealt in accordance with agreed procedures and timescales	-	-	-	-	-	-	✓	-	-	-	-	-	-	✓	-	-	-	-	-	-	-
161	Responsibility for ensuring provision of timely information to enable the Trust to respond effectively to claims	-	✓	-	-	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	-
162	Responsibility for ensuring appropriate remedial action is taken / lessons learnt are shared for claims	-	✓	-	-	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	-
163	Engagement of Trust solicitors	-	-	-	-	-	-	-	✓	-	-	-	-	-	✓	-	-	-	-	-	-	-
164	**COMPLIANCE WITH ALL STATUTORY LEGISLATION AND HEALTH AND SAFETY REQUIREMENTS**																					
165	Review of Fire Precautions (Nominated Fire Officer)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	✓	-	-	-	-	-
166	Responsible for ensuring adequate processes are in place to ensure compliance	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	✓	-	-	-	-	-
167	Responsible for ensuring staff awareness and compliance with H&S policies and procedures	-	✓	-	-	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	-	-	-
168	Responsible for identification of designated leads to co-ordinate health & safety arrangements at local level	-	✓	-	-	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	-	-	-
169	Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	✓	-	-	-	-	-
170	Review of Medicines Inspectorate regulations	-	-	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-
171	Compliance with the Informatics Governance Legislation	-	-	-	-	-	-	✓	-	-	-	-	-	✓	-	✓	-	-	-	-	-	-
172	Infectious Diseases and Notifiable Outbreaks	-	-	-	-	-	-	✓	-	-	✓	✓	-	-	-	-	-	-	-	-	-	-
173	**AUTHORISATION OF NEW DRUGS (including research projects and clinical trials)**																					
174	Authorisation of new drugs - approved by Medicines & Therapeutic Committee	-	✓	-	-	-	-	-		-	-	-	-	-	-	-	-	-	-	-	-	✓
175	Research/clinical trials - Ethical Approval	-	-	-	-	-	-	-	-	✓	✓	✓	-	-	-	-	-	-	-	-	-	-
176	Research/clinical trials - Funding	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
177	Authorisation of Research Projects	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
178	Authorisation of Clinical Trials	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
179	Authorisation of pharmaceutical sponsorship agreements - in line with Standards of Business Conduct Policy	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
180	**RETENTION OF RECORDS**																					
181	Clinical	-	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-
182	Financial records	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-
183	Other (as appropriate)	-	✓	-	-	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	-	-	-
184	Approval to permanently delete IT systems (on the rec of the Chief Digital Information Officer and Digital Strategy Board)	-	✓	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
185	**IMPLEMENTATION OF NICE GUIDANCE**																					
186	Overall responsibility for ensuring arrangements are in place for the Trust to implement NICE guidance	-	✓	-	-	-	-	✓	-	✓	✓	-	-	-	-	-	-	-	-	-	-	-
187	Ensuring operational arrangements are in place to ensure implementation of NICE guidance	-	✓	-	-	-	-	✓	-	✓	✓	-	-	-	-	-	-	-	-	-	-	-
188	**MISCELLANEOUS DELEGATED AUTHORITY**																					
189	Caldicott Guardian	-	-	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-
190	Clinical Audit and Quality	-	-	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-	-	-	-	-
191	Relationships with Press - within hours - Director of Communications & Engagement	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
192	Relationships with Press - outside hours - On-Call Director / Director of Communications & Engagement	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
193	The keeping of Registers for Declarations of Interest, Hospitality, Sponsorship and Gifts - all staff	-	-	-	-	-	-	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-
194	Attestation of sealings in accordance with Standing Orders	-	-	-	-	-	-	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-
195	The keeping of a register of sealings	-	-	-	-	-	-	-	-	-	-	-	-	-	✓	-	-	-	-	-	-	-
196	Compliance with requirements of the Civil Contingencies Act	-	-	-	-	-	-	✓	-	✓	-	-	-	-	-	-	-	-	-	-	-	-

(Note: a tick followed by an asterisk indicates that both delegated officers are required to give authority)

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)150

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	8 August 2024
Director Lead	Lee Bond – Group Chief Financial Officer
Contact Officer / Author	Lee Bond Sally Stevenson – Assistant Director of Finance – Compliance and Counter Fraud
Title of Report	**Group Standing Financial Instructions – Draft for Approval**
Executive Summary	The existing Standing Financial Instructions (SFI's) for Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) and Hull University Teaching Hospitals NHS Trust (HUTH) were initially reviewed and aligned, with a separate set of SFI's produced for each Trust. These draft documents were circulated to the Group Executive Cabinet for its meeting on 28 May 2024, following which it was agreed to produce one combined SFI document for NHS Humber Health Partnership (the Group). Comments received from Executive Directors were duly reviewed and incorporated as appropriate. The resulting combined Group SFI document was then circulated to the Audit, Risk and Governance Committees-in-Common (ARG ciC) Non-Executive Directors (NEDs), Trust Chair and Trust Vice Chairs and Group Director of Assurance on 1 July 2024. Comments received were once again duly reviewed and incorporated as appropriate. The draft SFI document was then received and endorsed at the meeting of the ARG CiC on 25 July 2024, prior to submission to the Trust Boards-in-Common. **The Trust Boards-in-Common are asked to consider and approve the draft Group Standing Financial Instructions.**
Background Information and/or Supporting Document(s) (if applicable)	Existing SFI's for each Trust.
Prior Approval Process	As set out above.
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	✓ Approval ☐ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Directorate of Finance

GROUP

(NHS HUMBER HEALTH PARTNERSHIP)

STANDING FINANCIAL INSTRUCTIONS

INCORPORATING STANDING ORDERS RELATING TO TENDERING AND CONTRACTING PROCEDURES

Reference:	
Version:	
This version issued:	
Result of last review:	
Date approved by owner (if applicable):	
Date approved:	
Approving body:	Audit, Risk and Governance Committees-in-Common / Group Trust Board
Date for review:	
Owner:	Lee Bond, Group Chief Financial Officer
Document type:	Miscellaneous
Number of pages:	63 (including front sheet)
Author / Contact:	Lee Bond / Sally Stevenson, Assistant Director of Finance – Compliance and Counter Fraud

Contents

1.0 Introduction

1.1 General

1.1.1 **Northern Lincolnshire and Goole NHS Foundation Trust** (hereafter referred to as 'NLAG') achieved Foundation Trust status on 1st May 2007 following approval by the Independent Regulator at that time (Monitor). **Hull University Teaching Hospitals NHS Trust** (hereafter referred to as 'HUTH') is a statutory body which came into existence on 1 October 1999, with the organisation formally changing its name to incorporate its Teaching Trust status on 1 March 2019.

1.1.2 In 2023 the two Trusts agreed to form a Group operating model with a single harmonised Executive team and leadership structure. Whilst both organisations retain their individual sovereignty, there is aligned corporate governance and decision making across the Group. This means that as much decision making as is practicable will take place via a 'committees-in-common' (CiC) approach for both the Trust Boards and its Board sub-committees. Further details are set out in the Board and Committees-in-Common Principles Framework (DCP427). In addition, there is a Group Memorandum of Understanding which sets out the framework through which both Trusts have a shared commitment to working more closely together. The Group name is **NHS Humber Health Partnership** (hereafter referred to as 'the Group').

1.1.3 These Standing Financial Instructions apply to the Group unless expressly stated otherwise throughout, to account for any variations between NHS Foundation Trust status (NLAG) and NHS Trust status (HUTH).

1.1.4 All references within this document to Trust Board Executive positions, such as the Chief Executive and the Chief Financial Officer relate to their Group Executive titles i.e. Group Chief Executive and Group Chief Financial Officer.

1.1.5 These Standing Financial Instructions (SFIs), incorporating the Trust's Standing Orders (SOs) relating to Tendering and Contracting Procedures, provide a comprehensive business and financial framework within which all executive directors, non-executive directors and officers of the Trust are expected to work. All executive and non-executive directors and all officers should be aware of the existence of these financial governance documents and, where necessary, be familiar with the detailed provisions contained therein.

1.1.6 These Standing Financial Instructions (SFIs) shall have effect as if incorporated in the Constitution (NLAG) and Standing Orders (SOs) (HUTH) of the Trust's.

1.1.7 These documents fulfil the dual role of protecting the Group's interests and protecting officers from any possible accusation that they have acted less than properly in the conduct of their duties.

1.1.8 These SFIs detail the financial responsibilities, policies and procedures to be adopted by the Group. They are designed to ensure that its financial transactions are carried out in accordance with the law and the requirements of the Independent Regulator in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Group 'Trust Scheme of Delegation and Powers Reserved for the Trust Board' formally adopted by the Group (collectively called the Group Scheme of Delegation).

1.1.9 These SFIs identify the financial responsibilities which apply to everyone working for the Group and its constituent organisations. They do not provide detailed procedural

advice. These statements should therefore be read in conjunction with the relevant detailed departmental and financial policies and procedure notes. All financial policies and procedures must be approved by the Chief Financial Officer and the appropriate committee of the Trust Boards-in-Common (e.g., the Audit, Risk and Governance Committees-in-Common).

1.1.10 Should any difficulties arise regarding the interpretation or application of any of the SFIs, then the advice of the Chief Financial Officer **must be sought before acting**. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's SOs (contained within the Trust Constitution for NLAG), particularly in relation to tending and contracting procedures at Appendix A. Where other guidance or policies appear to conflict with the SFI's, the SFI's will override those policies or procedures.

1.1.11 Failure to comply with SFIs and SOs is a disciplinary matter that could result in dismissal.

1.1.12 Overriding Standing Financial Instructions - if for any reason these SFIs are not complied with, full details of the non-compliance and justification for non-compliance shall be reported to the Chief Financial Officer and escalated to the Audit, Risk and Governance Committees-in-Common as appropriate for referring action or ratification. All members of the Trust Boards-in-Common and officers have a duty to disclose any non-compliance with these SFIs to the Chief Financial Officer as soon as possible.

1.2 Interpretation

1.2.1 Any expression to which a meaning is given in the 2006 National Health Service Act and other Acts relating to the NHS, or in financial directions and guidance issued by the Independent Regulator made under such Acts or regulations made under such Acts, shall have the same meaning in these SFIs. The following terms shall, where the context permits, have the meanings set out below:

"Accounting Officer (NLAG) / Accountable Officer (HUTH)" means the person who is responsible and accountable for the funds entrusted to the Trust. They shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust, it shall be the Chief Executive

"Audit, Risk and Governance Committee" means the committee established in accordance with the Standing Orders (HUTH) and Constitution (NLAG) and SFIs . See also Committees-in-Common

"**Authorisation**" means the terms of authorisation for NLAG as authorised by the Independent Regulator (NHSE)

"Board of Directors" and (unless the context otherwise requires) "**Board**" means the executive and non-executive directors of the Group, including the Chair, collectively as a body called the Trust Boards-in-Common. See also Committees-in-Common.

"Budget" means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust

"Budget Holder" means the director or officer with delegated authority to manage finances (income and expenditure) for a specific area of the organisation

"Chair of the Board (or Trust)" is the person appointed by the Council of Governors (NLAG) / Secretary of State for Health (HUTH) to lead the Board of Directors and to ensure that it successfully discharges its overall responsibility for the Group as a whole. The expression "the Chair" shall be deemed to include the vice Chair or such other person so appointed if the Chair is absent from the meeting or is otherwise unavailable

"Chief Executive" means the Group Chief Executive Officer (and Accounting Officer (NLAG) / Accountable Officer (HUTH)) of the Trust appointed in accordance with the Constitution (NLAG) and Standing Orders (HUTH)

"Commissioning" means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources

"Committee" means a committee of the Board of Directors, appointed by the Board and which reports to the Board

"Committees-in-Common" (CiC) means committees of each Trust within the Group which meet simultaneously with the corresponding committee from the other Trust but remain separately constituted committees and take their own decisions. Further details are set out in the Board and Committees-in-Common Principles Framework (DCP427)

"**Committee member**" means a person appointed by the Board to sit on or to chair a specific committee

"Constitution" means the Constitution of NLAG as authorised by the Independent Regulator

"Council of Governors" means the Council of Governors of NLAG, as constituted by the NLAG Constitution

"Chief Financial Officer" means the Group Chief Financial Officer of the Group appointed in accordance with the Constitution (NLAG) and Standing Orders (HUTH)

"**Employee**" means a person paid via the payroll of either Trust, or for whom the Trust has responsibility for making payroll arrangements, but excluding Non-Executive Directors

"Executive Director" means a Member of the Board of Directors who holds an executive office of the Group appointed in accordance with the Constitution (NLAG) and Standing Orders (HUTH)

"External Auditor" means the external auditor function described in the Group SFI's appointed by the Council of Governors in accordance with the Constitution (NLAG) or the Auditor Panel and Trust Board (HUTH)

"Funds Held on Trust" means those funds which the Trusts hold at its date of incorporation or chooses subsequently to accept. Such funds may or may not be charitable

"Group" means the Group model operating between Northern Lincolnshire and Goole NHS Foundation Trust and Hull University Teaching Hospitals NHS Trust, known as NHS Humber Health Partnership

"Independent Regulator" means NHS England (NHSE), the regulator of NHS Trusts and Foundation Trusts

"Internal Audit" means the function described in the Group SFI's

"Legal Advisor" means the properly qualified person(s) appointed by the Trusts to provide legal advice

"Licence" means the NHS Provider Licence issued by the Independent Regulator (NHSE)

"**Local Counter Fraud Specialist**" means the officer who has daily operational responsibility for implementing the requirements of the relevant service conditions of the NHS Standard Contract in relation to counter fraud arrangements

"Member of the Board" means an Executive or Non-Executive Director. (Member of the Board in relation to the Board of Directors includes its Chair)

"Nominated Officer" means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions

"Non-Executive Director" means a Member of the Board of Directors who does not hold an executive office of the Trust and is appointed independently of the Trusts Executive in accordance with the Constitution (NLAG) / NHS Trusts (Membership and Procedure) Regulations (HUTH). This includes the Chair of the Group.

"Officer" means an employee of either Trust or any other person holding a paid appointment or office with either Trust, and employee shall be deemed to include employees of third parties contracted to either Trust when acting on behalf of either Trust

"Remuneration Committee" means a committee carrying out the functions described in the Group SFIs

"Scheme of Delegation and Trust Devolution Policy" means the formal Group document containing the Reservation of Powers to the Board and the Scheme of Delegation for the Group

"SFIs" means these Standing Financial Instructions of the Group

"SOs" means the Standing Orders of the Group (as contained within the Trust Constitution for NLAG)

"the 2006 Act" means the National Health Service Act 2006

"Trust" means Northern Lincolnshire and Goole NHS Foundation Trust and / or Hull University Teaching Hospitals NHS Trust where specified

1.2.2 Wherever the title Chief Executive, Chief Financial Officer or other nominated officer is used in these instructions, it shall be deemed to include such other director or officers who have been duly authorised to represent them.

1.3 Responsibilities and Delegation

1.3.1 The **Board of Directors** has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These are set out in the

'Powers Retained by the Board' contained within the Group Scheme of Delegation document.

1.3.2 The Board of Directors will delegate responsibility for the performance of its functions to executive directors or committees of the Board in accordance with the Group Scheme of Delegation document formally adopted by the Group. The Board must approve the membership and terms of reference of all committees reporting directly to the Board. The extent of delegation will be kept under review by the Board.

1.3.3 The Board of Directors exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within an approved financial plan;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

(d) defining specific delegated responsibilities placed on directors and employees as indicated in the Group Scheme of Delegation document containing the powers of delegation and reservations as the Group has established.

1.3.4 The **Chief Executive** has overall executive responsibility for the Group's activities, is responsible to both Trust's Board of Directors (which meet as Trust Boards-in-Common) for ensuring that its financial obligations and targets are met and has overall responsibility for the Group's system of internal control. Within these SFIs, it is acknowledged that the Chief Executive is ultimately accountable to both Trust's Board of Directors and as Accounting Officer (NLAG) / Accountable Officer (HUTH), to the Independent Regulator and to Parliament for ensuring that the Board of Directors meets its obligation to perform its functions within the available financial resources. The Chief Executive will at all times comply, for NLAG, with the NHS Foundation Trust Accounting Officer Memorandum (August 2015).

1.3.5 The Chief Executive and Chief Financial Officer will, as far as is appropriate, delegate their detailed responsibilities but they remain accountable for financial control.

1.3.6 It is a duty of the Chief Executive to ensure that existing directors and officers and all new appointees are notified of and put in a position to understand their responsibilities within these SFIs.

1.3.7 The **Chief Financial Officer** is responsible for:

(a) Ensuring that these SFIs are appropriate and up to date;

(b) implementing the Group's financial policies and for co-ordinating any corrective action necessary to further these policies;

(c) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these SFIs;

(d) ensuring that sufficient records are maintained to show and explain each Trust's transactions in order to disclose, with reasonable accuracy, the financial position of each Trust at any time; and

(e) without prejudice to any other functions of directors and employees to each Trust:

i. the provision of financial advice to the Trust and its directors and employees;

ii. the design, implementation and supervision of systems of internal financial control; and

iii. the preparation and maintenance of such accounts, certificates, estimates, records and reports as each Trust may require for the purpose of carrying out its statutory duties.

1.3.8 **All Directors and Officers**, severally and collectively, are responsible for:

(a) the security of the property of the Group;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources; and

(d) conforming to the requirements of the Independent Regulator, the Provider Licence, the Trust Constitution (NLAG), Standing Orders, Standing Financial Instructions, financial policies and procedures and the Scheme of Delegation.

1.3.9 Any **contractor, or officer of a contractor**, who is empowered by either Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these SFIs. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.3.10 For any and all directors and officers who carry out a financial function, the form in which financial records are kept and the manner in which directors and officers discharge their duties must be to the satisfaction of the Chief Financial Officer.

1.3.11 It shall be the duty of any officer having evidence of, or reason to suspect, financial or other irregularities or impropriety in relation to these SFIs to report these suspicions without delay to the Chief Financial Officer and/or the Trust's Local Counter Fraud Specialist for further investigation and action as appropriate, in line with each Trust's 'Local Counter Fraud, Bribery and Corruption Policy and Response Plan'.

2.0 Annual Accounts and Reports

2.1 The Chief Financial Officer, on behalf of each Trust, will:

(a) keep accounts and in respect of each financial year must prepare annual financial accounts, in such form as the Independent Regulator may, with the approval of HM Treasury, direct

(b) ensure that, in preparing annual accounts, each Trust complies with any directions given by the Independent Regulator with the approval of HM Treasury as to:

i. the methods and principles according to which the accounts are to be prepared; and

ii. the information to be given in the accounts;

(c) ensure that a copy of the annual accounts and any report of the External Auditor on them are laid before Parliament (NLAG only) and that copies of these documents are sent to the Independent Regulator in accordance with the timescales prescribed.

2.2 Each Trust's annual accounts, financial returns and annual report must be audited by the Trust's External Auditor in accordance with appropriate auditing standards.

2.3 Each Trust's Audited Annual Accounts (including the Auditor's report) must be presented to the Board of Directors for approval or the Audit, Risk and Governance Committee (when specifically delegated the power to do so, under the authority of the Board of Directors) and received by the Council of Governors (NLAG) at a public meeting by 30 September each year. Each Trust's audited accounts must be made available to the public.

2.4 The Director of Assurance, on behalf of each Trust, will prepare an annual report in accordance with the requirements of NHSE's NHS Foundation Trust Annual Reporting Manual (NLAG) / Department of Health and Social Care (DHSC) Group Accounting Manual (HUTH). This annual report will be presented to the Board of Directors for approval, or the Audit, Risk and Governance Committee when specifically delegated the power to do so by the relevant Trust Board, and received by the Council of Governors (NLAG) at a public meeting. A copy will be forwarded to the Independent Regulator in line with the prescribed timescales.

3.0 Audit and Counter Fraud

3.1 Audit, Risk and Governance Committees-in-Common

3.1.1 In accordance with the Trust Constitution (NLAG) and SOs (and as set out in NHS England's Code of Governance for NHS Provider Trusts and its publication 'Audit and assurance: a guidance to governance for providers and commissioners', the Board of Directors shall establish a committee of non-executive directors at each Trust as an Audit, Risk and Governance Committee, which will meet simultaneously as committees-in-common, with formal terms of reference, approved by the Board, to perform such monitoring, reviewing and other functions as are appropriate to provide an independent and objective view of internal control.

3.1.2 The Board of Directors shall satisfy itself that at least one member of each Audit, Risk and Governance Committee has recent and relevant financial experience.

3.1.3 The Audit, Risk and Governance Committees-in-Common will provide an independent and objective view of internal control by:

(a) overseeing audit arrangements, including strategic and annual audit plans for Internal and External Audit services on behalf of the Trust Boards;

(b) reviewing financial information and systems and monitoring the integrity of the financial statements and reviewing significant reporting judgements, including the draft Annual Accounts for each Trust;

(c) reviewing the establishment and maintenance of an effective system of governance, risk management and internal control across the whole of each Trust's activities (both clinical and non-clinical);

(d) reviewing schedules of write-offs and Losses and Compensations on behalf of the Boards and reviewing all occasions on which the Trust Boards waiver standing orders;

(e) ensuring that agreed actions and recommendations arising out of internal and external audit reports are appropriately progressed;

(f) monitoring compliance with SOs and SFIs;

(g) reviewing the work of other committees and other significant assurance providers, where relevant and appropriate;

(h) overseeing counter fraud arrangements provided by the Local Counter Fraud Specialist within each Trust; and

(i) ensuring that the function of the Audit, Risk and Governance Committee complies, as appropriate, with the latest Healthcare Financial Management Association (HFMA) NHS Audit Committee Handbook recommendations.

3.1.4 The NLAG Audit, Risk and Governance Committee shall make a recommendation to the Council of Governors with respect to the re-appointment of the Trust's external auditors. As a NHS Foundation Trust, the Council of Governors is responsible for the appointment of NLAG's external auditors. If their work has been satisfactory and the charges reasonable, the Council of Governors may re-appoint the auditors for the following year without the need for a formal selection process. However, the Trust

will undertake a market-testing exercise for the appointment of the external auditor at least once every five years.

3.1.5 The HUTH Audit, Risk and Governance Committee shall be involved in the selection process when the external audit providers is changed. When appointing external auditors the HUTH Audit, Risk and Governance Committee will be the 'Auditor Panel' and make a recommendation to the Trust Board with respect to the appointment of the Trust's external auditors. If their work has been satisfactory and the charges reasonable, the Trust Board may re-appoint the auditors for an extension year option (if contained within the contract) without the need for a formal selection process. However, the Trust will undertake a market-testing exercise for the appointment of the external auditor at least once every five years.

3.1.6 The Audit, Risk and Governance Committees-in-Common shall appoint the Trust's internal auditor(s) and will be involved in the selection process when an internal audit service provider is changed. Each Trust will undertake a market-testing exercise for the appointment of the internal auditor at least once every five years.

3.1.7 Where the Audit, Risk and Governance Committee of either Trust feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit, Risk and Governance Committee concerned should raise the matter at a full meeting of the Board of Directors. Exceptionally, the matter may need to be referred to the Independent Regulator via the Chief Financial Officer in the first instance.

3.2 Chief Financial Officer

3.2.1 The Chief Financial Officer is responsible for:

(a) ensuring that there are arrangements to review, evaluate and report on the effectiveness of internal financial control, including the establishment of an effective internal audit function;

(b) ensuring that internal audit is adequate and effective and meets the standards of the Independent Regulator;

(c) deciding at what stage to involve the police and liaising with the Independent Regulator as appropriate in cases of misappropriation and other irregularities not involving fraud and corruption;

(d) ensuring that an annual internal audit report is provided for each Trust by the Head(s) of Internal Audit for consideration by the Audit, Risk and Governance Committee on a timely basis. The annual report must cover:

i. a clear opinion on the effectiveness of internal control in accordance with current assurance guidance issued by the Independent Regulator, including for example compliance with control criteria and standards;

ii. progress against plan over the previous year;

iii. major internal financial control weaknesses discovered; and

iv. progress on the implementation of Internal Audit recommendations.

(e) ensuring that a risk based internal audit plan for the coming year is produced and approved by the Audit, Risk and Governance Committee.

3.2.2 The Chief Financial Officer or designated internal/external auditor is entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature

(b) access at all reasonable times to any land, premises, Trust Board member or officer of the Trust;

(c) the production of any cash, stores or other property of the Trust under an officer's control; and

(d) explanations concerning any matter under investigation.

3.3 External Audit

3.3.1 It is for the Council of Governors at NLAG, with advice from the Audit, Risk and Governance Committee, to appoint or remove the External Auditor at a general meeting of the Council of Governors in accordance with the Constitution. It is for the Trust Board at HUTH, with advice from the Audit, Risk and Governance Committee who act as the Auditor Panel to appoint or remove the External Auditor.

3.3.2 The initial appointment of the External Auditor must be made as soon as possible and no later than the end of the first period for which the Trust will be preparing accounts.

3.3.3 The Trust must ensure that the External Auditor appointed by the Council of Governors (NLAG) or the Trust Board (HUTH) meets the criteria included by NHS England within the Code of Governance for NHS Provider Trusts and its publication 'Audit and assurance: a guidance to governance for providers and commissioners' , at the date of appointment and on an on-going basis throughout the term of their appointment.

3.3.4 The External Auditor must ensure that a cost-efficient service is provided, agree work plans (except for statutory requirements) and comply with the audit code issued by the National Audit Office (NAO).

3.3.5 Prior approval must be sought from the Audit, Risk and Governance Committee (at NLAG the Council of Governors may also be notified for information) for each discrete piece of additional external audit work (i.e., over and above the audit plan approved at the start of the year) awarded to the external auditors. Competitive tendering is not required and the Chief Financial Officer is required to authorise expenditure associated with such additional work. See also 3.3.9 in relation to non-audit work permitted to be undertaken by the Trust's External Auditor.

3.3.6 In the case of an emergency, external audit shall be permitted to carry out additional discrete pieces of work if authorised to do so by the Chief Executive, the Chief Financial Officer and the Chair of the relevant Trust's Audit, Risk and Governance Committee; this shall be reported to the next meeting of the Audit, Risk and Governance Committee.

3.3.7 The Trusts will provide the external auditor with every facility and all information which he/she may reasonably require for the purposes of his/her functions under Schedule 10 of the 2006 Act.

3.3.8 Where the External Auditor issues a public interest report the Trust concerned shall forward a report to the Independent Regulator either at once if it is an immediate report or otherwise not later than fourteen days after conclusion of the audit (as per the NHS Act 2006 Schedule 10). The report shall include details of the relevant Trust's response to the issues raised within the public interest report.

3.3.9 In line with guidance issued by the Independent Regulator, the Trusts shall implement a policy for approving any non-audit services that are to be provided by the Trust's External Auditor. It is important that the independence of the External Auditor is not, or does not appear to be, compromised in terms of the objectivity of their opinion on the financial statements of the Trust concerned. Each Trust's policy document 'Policy for the Engagement of External Auditors for Non-Audit Work' refers.

3.4 Role of Internal Audit

3.4.1 Internal Audit provides an independent and objective opinion to the Chief Executive, the Audit, Risk and Governance Committee and the Board on the degree to which risk management, control and governance arrangements support the effective operation of the Trust and the achievement of the Trust's agreed objectives. Internal Audit will, in accordance with recognised professional best practice, review, evaluate and report upon:

(a) the effectiveness of the Trust's operations and the management of the risks associated with those operations;

(b) the extent of compliance with, and the financial effect of or risk associated with, relevant established policies, plans, procedures, laws and regulations;

(c) the adequacy and application of financial and other related management controls;

(d) the suitability and effective usage of financial and other related management information and data, including internal and external reporting and accountability processes;

(e) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

i. fraud and other offences;

ii. waste, extravagance and inefficient administration;

iii. poor value for money;

iv. any form of risk, especially business and financial risk but not exclusively so.

(f) The adequacy of follow-up actions by the Trust to internal audit reports;

3.4.2 The Head(s) of Internal Audit will produce an annual audit opinion on the effectiveness of the system of internal control for each Trust within the Group.

3.4.3 The Head of Internal Audit will make suitable provision to form an opinion on key systems operated on behalf of other organisations, and key systems being operated by other organisations, either by deriving the opinions themselves or by relying on the opinions provided by other auditors/review bodies.

3.4.4 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Financial Officer must be notified immediately (see also SFI 13 – Disposals and Condemnations, Losses and Special Payments) and in the case of alleged or suspected fraud, the Local Counter Fraud Specialist must be notified.

3.4.5 The Head(s) of Internal Audit and/or the Internal Audit Manager(s) for the Trusts will normally attend Audit, Risk and Governance Committee meetings and has a right of access to all Audit, Risk and Governance Committee members, the Chair and Chief Executive of the Trust.

3.4.6 The Head(s) of Internal Audit shall be accountable to the Chief Financial Officer.

3.4.7 The reporting system for internal audit shall be agreed between the Chief Financial Officer, the Audit, Risk and Governance Committee and the Head(s) of Internal Audit. The agreement shall be in writing and shall comply with appropriate guidance. The reporting system shall be reviewed at least every three years. Where, in exceptional circumstances, the use of normal reporting channels could be seen as a possible limitation on the objectivity of the audit, the Head(s) of Internal Audit shall have access to report directly to the Chief Executive, Chair or any non-executive Director of the Trust.

3.4.8 The Head(s) of Internal Audit shall co-ordinate internal audit plans and activities with line managers, external audit and other review agencies to ensure that the most effective audit coverage is achieved and duplication of effort is minimised.

3.4.9 The Trust(s) will provide the Head(s) of Internal Audit with every facility and all information which he/she may reasonably require for the purposes of his/her functions under the terms of reference.

3.5 Fraud, Bribery and Corruption

3.5.1 The Chief Financial Officer, as the executive board member responsible for countering fraud, bribery and corruption in the Trust, shall monitor and ensure compliance with the NHS Standard Contract Service Condition 24 to put in place and maintain appropriate anti-fraud, bribery and corruption arrangements, having regard to the NHS Counter Fraud Authority (NHS CFA) provider standards.

3.5.2 The Trusts shall nominate a suitable person to carry out the duties of the professionally accredited Local Counter Fraud Specialist (LCFS) in accordance with NHS CFA's' provider standards.

3.5.3 The LCFS shall report directly to the Trust's Chief Financial Officer. The LCFS shall work with staff in the NHS CFA as necessary.

3.5.4 The LCFS will provide a written report, at least annually, on counter fraud work within the Trust(s) to the Audit, Risk and Governance Committee and the Board.

3.5.5 The Chief Financial Officer shall review and sign off the annual Counter Fraud Functional Standards Return (CFFSR) of each organisations arrangements for

meeting the NHS provider standards in relation to anti-fraud, bribery and corruption measures and ensure its submission to the NHS CFA is in line with the required deadline.

3.5.6 The Chief Financial Officer is responsible for providing detailed procedures to enable the Trust to minimise and, where possible, to eliminate fraud and corruption. The Trust's 'Local Counter Fraud, Bribery and Corruption Policy and Response Plan' sets out action to be taken by persons detecting a suspected fraud and persons responsible for investigating it.

3.5.7 It is expected that all officers shall act with the utmost integrity, ensuring adherence to all relevant regulations and procedures. It is the responsibility of the Chief Financial Officer to produce and issue these regulations and procedures to the appropriate Directors and Managers who should ensure that all staff have access to these.

3.5.8 Both Internal and External Audit shall be informed of all suspected, alleged or detected fraud so that they can consider the adequacy of the relevant controls and evaluate the implication of fraud for their opinion on the system of risk management, control and governance.

3.5.9 Any officer discovering or suspecting fraud and/or corruption must inform the Trust's LCFS or Chief Financial Officer without delay. Details of how to report a fraud are shown in the Trust's 'Local Counter Fraud, Bribery and Corruption Policy and Response Plan'.

3.5.10 The Chief Financial Officer is responsible for ensuring that action is taken to investigate any allegations of fraud or corruption through the LCFS.

4.0 Business Planning, Budgets, Budgetary Control and Monitoring

4.1 Preparation and Approval of Annual Plans and Budgets

4.1.1 The Chief Executive is responsible for ensuring that at least every five years or more regularly as required, a statement of strategic direction is prepared for approval by the Board of Directors for each Trust.

4.1.2 The Chief Executive is responsible for ensuring that an Annual Plan is compiled and submit to the Board of Directors for each Trust. The Annual Plan will contain:

(a) a statement of the significant assumptions on which the plan is based; and

(b) details of any major changes in workload, delivery of services or resources required to achieve the plan.

4.1.3 All budget holders must provide information as required by the Chief Financial Officer to enable budgets to be compiled.

4.1.4 Each Trust will provide its Annual Plan to the Independent Regulator on an annual basis. This information will be prepared by the directors, who must have regard to the views of the Council of Governors at NLAG.

4.1.5 Prior to the start of the financial year, the Chief Financial Officer will, on behalf of the Chief Executive, prepare and submit annual budgets for approval by the Board of Directors. Such budgets will:

(a) be in accordance with the aims and objectives set out in the Annual Plan;

(b) accord with workload and manpower plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available funds;

(e) identify potential risks;

(f) be based on reasonable and realistic assumptions; and

(g) comply with any NHS England requirements and any other regulations.

4.1.6 The Chief Financial Officer shall monitor financial performance against financial, activity and other performance targets for each Trust and the Group overall. Performance reports shall be presented to the Board of Directors not less frequently than quarterly, and also to meetings of the Performance, Estates and Finance Committees-in-Common.

4.1.7 Officers shall provide the Chief Financial Officer with all financial, statistical and other relevant information necessary for the compilation of such budgets, plans, estimates and forecasts.

4.1.8 The Chief Financial Officer has a responsibility to ensure that adequate financial training is delivered on an on-going basis to budget holders to help them manage successfully.

4.1.9 Operating surpluses may be used to:

(a) spend on revenue;

(b) meet locally determined health needs;

(c) build up cash reserves for future investments;

(d) finance an investment or purchase; or

(e) make payments on a loan.

4.1.10 Operating surpluses may not be distributed to members.

4.1.11 The Chief Executive shall monitor and review performance against Business Cases and report to the Board. Business Cases will be reported to the Board by 'exception' where benefits have not been delivered as originally approved. All major business cases must be subject to a benefits realisation process, which will be monitored by the Capital and Major Projects Committee.

4.2 Budgetary Delegation

4.2.1 The Chief Executive and all delegated budget holders must not exceed the budgetary totals or virement limits set by the Board of Directors. All budget holders will sign up to their allocated budgets at the commencement of each financial year.

4.2.2 The Chief Executive, on the advice of the Chief Financial Officer, may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget;

(b) the purpose(s) of each budget heading;

(c) individual and group responsibilities;

(d) authority to exercise virement;

(e) achievement of planned levels of service; and

(f) the provision of regular reports.

4.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

4.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive or Chief Financial Officer.

4.3 Budgetary Control and Financial Reporting

4.3.1 The Chief Financial Officer will devise and maintain systems of budgetary control and financial reporting. These will include:

(a) regular financial reports to the Board of Directors (in addition to those provided to the Performance, Estates and Finance Committees-in-Common), in a form approved by the Board of Directors, containing sufficient information

to allow the Directors of the Board to ascertain the financial performance of the Trusts. This may include the following:

i. income and expenditure to date, showing trends and forecast year-end position;

ii. summary statement of cash flow and forecast year-end position;

iii. summary statement of financial position, including cost improvement plans;

iv. movements in working capital;

v. capital project spend and projected outturn against plan;

vi. explanations of any material variances that explain any movement from the planned retained surplus/deficit at the end of the current month position; and

vii. details of any corrective action required and the Chief Executive's and/or Chief Financial Officer's view of whether such action is sufficient to correct the situation.

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and manpower budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers.

4.3.2 The Chief Financial Officer shall keep the Chief Executive and the Board informed of the financial consequences of changes in policy, pay awards and other events and trends affecting budgets and shall advise on the financial and economic aspects of future plans and projects.

4.3.3 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior written consent of the Chief Financial Officer;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised in writing subject to the rules of virement;

(c) no permanent officers are appointed without the approval of the Chief Executive other than those provided for by the pay budget as approved by the Board of Directors; and that appointments are made subject to the Trust appointments process; and

(d) the systems of budgetary control established by the Chief Financial Officer are complied with fully.

4.3.4 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Trusts' Annual Plan and a balanced budget.

4.4 Capital Expenditure

4.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure (the particular applications relating to capital are contained in SFI 12).

4.5 Performance Monitoring Returns

4.5.1 The Chief Financial Officer is responsible for ensuring that the appropriate monitoring forms are submitted to the Independent Regulator and any other requisite monitoring organisation within the prescribed timescales; and also that:

(a) financial performance measures have been defined and are routinely monitored;

(b) reasonable targets have been identified for these measures;

(c) a robust system is in place for managing performance against the targets;

(d) reporting lines are in place to ensure that overall performance is managed effectively; and

(e) arrangements are in place to manage/respond to adverse performance.

5.0 Agreements for Provision of Services

5.1 Contracts with Commissioners

5.1.1 The Board of Directors shall regularly review and shall at all times maintain and ensure the capacity of the Trusts within the Group to provide the commissioner requested services referred to in the Provider Licence and other related schedules.

5.1.2 The Chief Executive, as Accounting Officer (NLAG) / Accountable Officer (HUTH), supported by the Chief Financial Officer, is responsible for ensuring that contracts are in place with commissioners for the provision of services to patients in accordance with the Annual Plans.

5.1.3 Contracts with commissioners shall comply with best costing practice and shall be so devised as to minimise contractual risk whilst maximising each Trust's opportunity to generate income. Contracts with commissioners are legally binding and appropriate legal advice, identifying the organisation's liabilities under the terms of the contract, should be considered.

5.1.4 Contracts with commissioners will be signed by both parties in accordance with the Group Scheme of Delegation.

5.1.5 In carrying out these functions, the Chief Executive should take into account the advice of the Chief Financial Officer regarding:

(a) costing and pricing of services (in accordance with the NHS Payment Scheme (NHPS)) and the activity/volume of services planned;

(b) payment terms and conditions;

(c) billing systems and cash flow management;

(d) any other matters of a financial nature;

(e) the contract negotiation process and timetable;

(f) the provision of contract data;

(g) contract monitoring arrangements;

(h) amendments to contracts; and

(i) any other matters of a legal or non-financial nature.

5.1.6 Prices should match NHPS, where appropriate, but the Trusts can negotiate locally agreed prices where services are not covered by the national tariff.

5.1.7 The Chief Financial Officer shall produce regular reports (in the form of service line reports) detailing actual and forecast service activity income with a detailed assessment of the impact of the variable elements of income for each Trust. These reports will be submitted to the Performance, Estates & Finance Committees-in-Common and the Trust Board.

5.1.8 The Trusts will maintain a public and up-to-date schedule of the authorised goods and services which are being currently provided, including non-mandatory health services, as set out in the Trust Provider Licence.

5.2 Other Contracts

5.2.1 Where a Trust enters into a relationship with another organisation for the supply or receipt of services – clinical or non-clinical – the responsible officer should ensure that an appropriate contract is in place and signed by both parties.

5.2.2 No officer shall enter into any form of contract on behalf of the Trust(s) unless they have specific authority to do so, in line with the Group Scheme of Delegation and relevant Trust policies and procedures. This applies even if the contract has no obvious financial value attached to it, e.g., agreements to advertise on Trust premises or documentation. Refer also to the Trust's 'Advertising Policy' (NLAG) / 'Communications Policy' for such agreements.

5.2.3 Contracts should incorporate:

(a) a description of the service and indicative activity levels;

(b) the term of the agreement (including actual commencement and expiry dates);

(c) the value of the agreement;

(d) lead officers;

(e) performance and dispute resolution procedures; and

(f) risk management and governance arrangements.

5.2.4 Contracts should be reviewed and agreed on an annual basis or as determined by the term of the agreement so as to ensure value for money and to minimise any potential loss of income.

5.3 Involving Partners and Jointly Managing Risk

5.3.1 A good contract will result from a dialogue of clinicians, users, carers, public, health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust(s) works with all partner agencies involved in both the delivery and the commissioning of the service required. The contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the risk in question and financial arrangements should reflect this. In this way the Trusts can jointly manage risk with all interested parties.

5.3.2 The Group has a duty to work together collaboratively with all other local stakeholders. The interests of the Group will not be pursued where this will adversely impact upon the interests of the local health and care system as a whole.

6.0 Bank Accounts

6.1 General

6.1.1 The Chief Financial Officer is responsible for managing each Trust's banking arrangements and for advising each Trust on the provision of banking services and operation of accounts. This advice will take into account the Independent Regulator's guidance and directions as issued from time to time.

6.1.2 The Board of Directors shall approve the banking arrangements.

6.2 Bank and Government Banking Service (GBS) Accounts

6.2.1 The Chief Financial Officer is responsible for:

(a) all bank accounts (including GBS accounts);

(b) establishing separate bank accounts for the Trust's non-exchequer funds;

(c) ensuring that payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;

(d) reporting to the Board all arrangements made with the relevant Trust's bankers for accounts to be overdrawn (together with remedial action taken); and

(e) monitoring compliance with HM Treasury guidance and any guidance issued by the Independent Regulator or any other relevant guidance on the level of cleared funds.

6.3 Banking Procedures

6.3.1 The Chief Financial Officer will prepare detailed instructions on the operation of bank and GBS accounts which must include:

(a) the conditions under which each bank account is to be operated;

(b) the limit to be applied to any overdraft; and

(c) those authorised to sign cheques or other orders drawn on each Trust's accounts and the limitation on single signatory payments.

6.3.2 The Chief Financial Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

6.3.3 The Chief Financial Officer must prepare detailed instructions on the investment policy in relation to the Trust's bank accounts.

6.3.4 All funds shall be held in accounts in the name of the Trust to which they relate. No officer other than the Chief Financial Officer shall open or close any bank account in the name of either Trust, following approval by the Trust Board in line with the Group Scheme of Delegation.

6.4 Tendering and Review

6.4.1 The Chief Financial Officer will review the commercial banking arrangements of each Trust at regular intervals not exceeding five years, to ensure that they reflect best practice and represent value for money by periodically reviewing competitive bank rates. Following such reviews, the Chief Financial Officer shall determine whether or not to seek competitive tenders for either of the Trust's commercial banking business.

6.4.2 The results of such reviews will be reported to the Audit, Risk and Governance Committee and the Board.

6.4.3 This review is not necessary for Government Banking Service accounts.

7.0 Income, Fees and Charges & Security of Cash, Cheques and Other Negotiable Instruments

7.1 Income Systems

7.1.1 The Chief Financial Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all income due to either Trust.

7.1.2 All such systems shall incorporate, where practicable, the principles of internal check and separation of duties.

7.1.3 The Chief Financial Officer is responsible for the prompt banking of all monies received by either Trust.

7.1.4 Each Trust will carry on activities for the purpose of making additional income available in order to better carry out the Trust's principal purpose, subject to any restrictions by the Independent Regulator (HUTH) or in the Independent Regulator's authorisation and as stated in the Constitution (NLAG).

7.2 Fees and Charges

7.2.1 Each Trust shall follow the Department of Health and Social Care (DHSC) NHS Payment Scheme guidelines and any other applicable guidance in setting prices for contracts with NHS commissioners for all services falling within the NHS Payment Scheme.

7.2.2 The Chief Financial Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the DHSC or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

7.2.3 Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered, the guidance in the DHSC's Commercial Sponsorship – Ethical Standards in the NHS shall be followed. Actions should also be in accordance with the Trust's policies on business and professional conduct.

7.2.4 In receiving cash payments, it should be noted that the maximum value of any single cash transaction is limited to the equivalent of less than 10,000 euros (regardless of currency). This is in line with the Money Laundering, Terrorist Financing and Transfer of Funds Regulations 2017.

7.2.5 All officers must inform the Chief Financial Officer promptly of income due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

7.3 Debt Recovery

7.3.1 The Chief Financial Officer is responsible for the appropriate recovery action on all outstanding debts.

7.3.2 Outstanding debts will be reviewed periodically and follow up action taken, dependent upon the value of the debt and length of time outstanding.

7.3.3 Income and salary overpayments not received after all attempts at recovery have failed should be dealt with in accordance with losses procedures (see also SFI 13 – Disposals and Condemnations, Losses and Special Payments).

7.3.4 Overpayments should be detected (or preferably prevented) and recovery initiated.

7.4 Security of Cash, Cheques and Other Negotiable Instruments

7.4.1 All officers have a responsibility to ensure that any Trust monies in their possession or under their responsibility are properly safeguarded and are held securely when not in use.

7.4.2 The Chief Financial Officer is responsible for:

(a) approving the form of all receipt books, agreement forms or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for officers whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys and for the opening of coin operated machines and subsequent counting and recording of takings from coin operated machines; and

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of each Trust.

7.4.3 An official receipt will be made out for all cash receipts when requested, showing the type of remittance and the reasons for payment.

7.4.4 A special receipt will be issued for all charitable fund donations, which will enable the donor to express their wishes as to the purpose of the donation.

7.4.5 Trust monies shall not under any circumstances be used for the encashment of private cheques or loans or IOUs.

7.4.6 All cheques, postal orders, cash, etc. shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Financial Officer.

7.4.7 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust shall not be held liable for any loss and written and signed indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

7.4.8 All unused cheques and other orders, where in use, shall be subject to the same security precautions as are applied to cash.

7.4.9 Where cash collection is undertaken by an external organisation, this shall be subject to such security and other conditions as required by the Chief Financial Officer.

7.4.10 Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be reported immediately in accordance with the agreed procedure for reporting losses (see also SFI 13 – Disposals and Condemnations, Losses and Special Payments). Any loss or surplus of cash should be immediately reported to the Chief Financial Officer.

7.4.11 All payments made on behalf of either Trust to third parties should normally be made using the Bankers Automated Clearing System (BACS), or by crossed cheque and drawn in accordance with these instructions, except with the agreement of the Chief Financial Officer, as appropriate, who shall be satisfied about security arrangements.

7.4.12 Staff shall be informed on their appointment of their responsibilities and duties for the collection, handling or disbursement of cash, cheques, etc.

8.0 Terms of Service and Payment of Directors and Officers

8.1 Remuneration and Terms of Service

8.1.1 In accordance with SOs, each Board shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts that fall within its area of responsibility, its composition and the arrangements for reporting. The operation of this committee will comply with all current regulatory and best practice requirements.

8.2 Funded Establishment

8.2.1 The workforce plans incorporated within the annual budget will form the funded establishment.

8.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive or nominated officer authorised by them, as referred to in the Group Scheme of Delegation.

8.2.3 Each Director must ensure that all of their budget holders operate within the agreed staffing establishment.

8.3 Staff Appointments

8.3.1 No director or officer may engage, re-engage or re-grade officers, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration unless:

(a) authorised to do so by the Chief Executive or person with delegated authority, in line with the Scheme of Delegation; and

(b) such engagement, re-engagement or re-grade is within the limit of his/her approved pay budget and funded establishment.

8.3.2 The Board of Directors will approve procedures presented by the Chief Executive for the determination of commencing pay rates and conditions of service for officers.

8.3.3 All staff engagements must comply with the latest regulations on staff appointments issued by the Independent Regulator and HM Revenue and Customs (HMRC).

8.4 Processing of Payroll

8.4.1 The Chief People Officer is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates; and

(d) agreeing methods of payment.

8.4.2 The Chief People Officer, in conjunction with the Chief Financial Officer as necessary, will issue instructions regarding:

(a) verification and documentation of payroll data;

(b) the timetable for receipt and preparation of payroll data and the payment of officers;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Acts;

(g) methods of payment available to various categories of officers;

(h) procedures for payment by bank credit, or other method when agreed, to officers;

(i) procedures for the recall of bank credits and other methods of payment;

(j) pay advances and their recovery;

(k) the establishment of suitable arrangements for the collection of payroll deductions and payment of these to appropriate bodies;

(l) maintenance of regular and independent reconciliation of pay control accounts;

(m) a system for the effective and timely recovery of payroll overpayments from existing members of staff; and

(n) a system to ensure the effective and timely recovery from leavers of sums of money and property due by them to the relevant Trust.

8.4.3 Appropriately nominated managers have delegated responsibility for:

(a) Submitting accurate time records (whether paper or electronic) and other notifications in accordance with agreed timetables;

(b) completing time records (whether paper or electronic) and other notifications in accordance with the Chief People Officer's instructions and in the form prescribed by the Chief People Officer; and

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an officer's resignation, termination or retirement, to ensure that overpayments to leavers do not occur. Where an officer fails to report for duty in circumstances that suggest they have left without notice, the Chief Financial Officer must be informed immediately to consider appropriate action to prevent or recover any overpayment.

8.4.4 Regardless of the arrangements for providing the payroll service, the Chief People Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, robust internal controls and suitable audit review procedures.

8.4.5 Managers and employees are jointly responsible and accountable for ensuring that claims for pay and expenses are timely and correct.

8.4.6 All employees have a responsibility to check their own payslips each month and bring any under or overpayments to the attention of the relevant Trust's Payroll and Pensions department as soon as discovered so that appropriate corrective action can be taken. The Trust has specific policies in relation to the recovery of salary overpayments and also the correcting of salary underpayments.

8.5 Contracts of Employment

8.5.1 It is the responsibility of the Chief People Officer for:

(a) ensuring that all employees are issued with a contract of employment in a form approved by the Board of Directors and which complies with employment legislation; and

(b) dealing with variations to, or termination of, contracts of employment.

9.0 Non-Pay Expenditure

9.1 Delegation of Authority

9.1.1 The Board of Directors will approve the level of non-pay expenditure as part of the annual budget and the Chief Executive will determine the level of delegation to budget managers prior to the start of the financial year to which the budget relates.

9.1.2 The Chief Executive will set out in the Group Scheme of Delegation:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services; and

(b) the maximum level of each requisition and the system for authorisation above that level.

9.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

9.1.4 At NLAG, the Council of Governors will be consulted on 'significant transactions' as defined in section 45 of the Trust's Constitution.

9.2 Tendering and Quotations

9.2.1 Wherever appropriate, the supply of goods and services shall be covered by a contract following a tender or quotation exercise. Trust policy and procedures in relation to the requirement to conduct a tender or quotation exercise are contained within these SFIs at Appendix A and delegated limits are set out in the Group Scheme of Delegation at Appendix A of that document.

9.2.2 The Chief Financial Officer, in conjunction with the Director of Procurement where appropriate, will:

(a) advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained. Once approved, the thresholds will be incorporated into SOs and the Group Scheme of Delegation (Appendix A) and regularly reviewed. These thresholds shall have effect as if incorporated into these SFIs; and

(b) prepare procedural instructions on the obtaining of goods, works and services incorporating the approved thresholds; and

(c) Prepare procedural instructions regarding the waiving of SO's and SFI's in relation to the procurement of goods and services. The Trusts Waiver Procedure can be found at Appendix B of these SFI's.

9.2.3 Approved thresholds will be applied to leases or recurring service contracts to the total costs over the term of the lease or contract.

9.3 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

9.3.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust concerned. In so doing, the advice of the Director of Procurement shall be sought. Where this advice is not

acceptable to the requisitioner, the Chief Financial Officer (and/or the Chief Executive) shall be consulted.

9.3.2 The Director of Procurement shall be responsible for ensuring that each Trust complies with all applicable laws in relation to choice, requisitioning, ordering and receipt for goods and services.

9.3.3 Once the item to be supplied (or service to be performed) has been identified the requisitioner should raise an official Trust requisition which will in turn generate an official Trust order to be raised. Only for agreed goods and services (e.g., utilities, NHS Supply Chain invoices, NHS Resolution invoices, etc.) should goods or services be obtained without an official requisition being raised and an official Trust order being generated. A list of approved items not requiring an official order will be maintained by the Finance Directorate showing who can authorise such items. Any new items / authorisers requested to be added to this list shall be approved by the Chief Financial Officer or the Chief Executive. **Raising a requisition at the time an invoice is received is not acceptable.**

9.3.4 The Chief Financial Officer shall be responsible for the prompt payment of all properly authorised accounts and claims. Payment of contract invoices shall be in accordance with contract terms or otherwise in accordance with national guidance.

9.3.5 In relation to supplies to and disposals by each Trust, the Chief Financial Officer will:

(a) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

i. A list of directors/officers (including specimens of their signatures) authorised to approve invoices for payment;

ii. Certification that:

- Goods and services ordered have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality and price and the charges for the use of vehicles, plant and machinery have been examined and are reasonable;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct; and
- the account is in order for payment.

- Where an officer certifying accounts relies upon other officers to do preliminary checking he/she shall, wherever possible, ensure that those who check delivery or execution of work act independently of those who have placed orders and negotiated prices and terms and that such checks are evidenced;

iii. A timetable and system for submission to the Chief Financial Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment;

iv. Instructions to officers regarding the handling and payment of accounts within the Finance Directorate.

(b) be responsible for ensuring that payment for goods and services is only made once the goods and services are received (except as per section 9.4 - Prepayments below);

(c) prepare and issue procedures regarding the treatment of Value Added Tax (VAT).

9.3.6 Purchasing cards may be operated in line with robust purchasing card procedures, as set out by the Chief Financial Officer.

9.4 Prepayments

9.4.1 Prepayments, other than those which are a legal contractual obligation or are standard practice such as certain utilities and software licences, are only permitted where exceptional circumstances apply. In such instances:

(a) prepayments are only permitted where the financial advantages outweigh the disadvantages;

(b) The supplier is of sufficient financial status or able to offer a suitable financial instrument to protect against the risk of insolvency;

(c) the appropriate Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the relevant Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;

(d) the Chief Financial Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed; and

(e) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or Chief Executive if problems are encountered.

9.5 Official Orders and Requisitions

9.5.1 Official Orders and requisitions must:

(a) be in a form approved by the Chief Financial Officer;

(b) be consecutively numbered;

(c) state the Trust's terms and conditions of trade; and

(d) only be raised by those duly authorised by the Chief Executive through the scheme of delegation.

9.6 Duties of Officers

9.6.1 All officers must ensure that they comply fully with the guidance and limits specified in Appendix A of the Group Scheme of Delegation and that:

(a) all contracts, leases, tenancy agreements and other commitments which may result in a liability, whether relating to land, buildings, vehicles or equipment shall be subject to authorisation by the Chief Financial Officer or by an officer so delegated by him/her, in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Independent Regulator;

(d) no order shall be issued for any item or items to any supplier/contractor that has made an offer of gifts, reward or benefit to any officer of the Trust, other than (and in line with the Trust's Standards of Business Conduct Policy (NLAG / Declaring Gifts and External Interests Policy (HUTH)):

i. low cost branded promotional aids such as pens or post it notes less than £6 in value; and

ii. conventional hospitality, such as lunches in the course of working visits.

(e) no requisition/order is placed for any item or items for which there is no budget provision, unless authorised by the Chief Financial Officer on behalf of the Chief Executive;

(f) all goods, services or works are ordered on an official order except those approved items not requiring an order as referred to in section 9.3.3, purchases from Trust petty cash and purchases using an official Trust purchasing card;

(g) verbal orders must only be issued very exceptionally by an officer designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

(h) orders are not split or otherwise placed in a manner devised so as to avoid the relevant financial thresholds, as outlined in the Group Scheme of Delegation;

(i) goods are not taken on trial or loan in circumstances that could commit the Trust concerned to a future uncompetitive purchase;

(j) changes to the list of directors/officers authorised to approve invoices for payment are notified to the Chief Financial Officer;

(k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Financial Officer (as set out in Appendix A of the Scheme of Delegation); and

(l) petty cash records are maintained in a form as determined by the Chief Financial Officer.

9.6.2 The technical audit of building and engineering contracts shall be the responsibility of the relevant Executive Director. The Chief Financial Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with best practice.

9.6.3 Under no circumstances should goods be ordered through either Trust for personal or private use (other than approved schemes such as lease cars or mobile phones).

10.0 Stores and Receipt of Goods

10.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use), should be:

(a) kept to a minimum;

(b) subjected to annual stock takes; and

(c) valued at the lower of cost and net realisable value.

10.2 Subject to the responsibility of the Chief Financial Officer for the systems of control, the day-to-day responsibility may be delegated to departmental officers and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Financial Officer.

10.3 The control of pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of fuel oil shall be the responsibility of a designated Estates manager.

10.4 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as property of the relevant Trust.

10.5 The Chief Financial Officer shall set out procedures and systems to regulate stores including:

(a) records for receipt of goods, issues and returns to stores;

(b) stocktaking arrangements (to include the requirement for a physical check covering all items in store at least once a year);

(c) stock valuation; and

(d) the review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable articles.

10.6 All goods shall be receipted by an appropriate officer in a timely manner once they are satisfied that the goods have been received by the Trust concerned.

10.7 Any proposed bulk purchases of inventory should be notified to the Chief Financial Officer and be authorised by them before a purchase is made.

10.8 Officers shall report to the Chief Financial Officer any evidence of significant overstocking, negligence or malpractice in relation to the management of stocks and stores (see also SFI 13 – Disposals and Condemnations, Losses and Special Payments).

11.0 External Borrowing and Investments

The Chief Financial Officer will be responsible for the management of each Trust's cash flow.

11.1 External Borrowing

11.1.1 The Chief Financial Officer will advise the Board of Directors concerning each Trust's ability to pay interest on, and repay, both the originating capital debt and any proposed new borrowing, within the limits set by NHS England for NHS organisations. The Chief Financial Officer is also responsible for reporting periodically to the Board of Directors concerning the originating debt and all loans, overdrafts and associated interest.

11.1.2 Any application for new borrowing will only be made by the Chief Financial Officer or by an officer so delegated by him/her. All such applications must be formally approved in advance in line with Appendix A of the Group Scheme of Delegation.

11.1.3 Assets protected under the authorisation agreement with the Independent Regulator shall not be used as collateral for borrowing. Non-protected assets will be eligible as security for a loan.

11.2 Investments

11.2.1 Temporary cash surpluses must be held only in such investments as approved by the Board of Directors and within the terms of guidance as may be issued by the Independent Regulator.

11.2.2 The Chief Financial Officer is responsible for advising the Board of Directors on investment strategy and shall report periodically to the Board of Directors concerning the performance of investments held.

11.2.3 The Chief Financial Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

12.0 Capital Investment, Fixed Asset Registers and Security of Assets

12.1 Capital Investment

12.1.1 The Chief Executive, supported by the Chief Financial Officer:

(a) Shall ensure that each Trust maintains a robust plan for capital investments which is subject to regular update to reflect both operational priorities for investment and the availability of resources;

(b) Shall ensure that this capital programme is subject to regular oversight and approval by the Capital and Major Projects Committee on behalf of the Trust Board, and that the Trust Board has formally approved the programme for each Trust and any mechanism to vary that programme at least annually as part of its approval of the wider Annual Plan for each Trust;

(c) All items on the investment programme for each Trust must be supported by either:

i. an agreed schedule of spend with explicitly stated governance arrangements; or

ii. a full business case setting out the parameters of the investment concerned.

These supporting schedules and business cases which will manage the investment programme must be reviewed and approved by the Capital and Major Projects Committee on behalf of the Trust Board. These must be approved in line with Appendix A of the Group Scheme of Delegation.

(d) shall ensure that there is a robust appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon annual plans; and that these are in line with guidance published by the Independent Regulator;

(e) shall ensure that robust arrangements are in place to effectively manage all stages of capital schemes and ensuring that schemes are delivered on time and to cost; and

(f) shall ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges.

12.1.2 Business cases on a significant enough scale to be considered major strategic decisions are required to be formally approved by the full Trust Board. This would take place after discussion at the Capital and Major Contracts Committee which would be expected to make a recommendation to the Trust Board. The thresholds above which a business case should be considered to have material strategic impact are shown in Appendix A of the Group Scheme of Delegation.

12.1.3 Day to day management and decision making in relation to the capital programme for each Trust remains the responsibility of the Chief Executive. The Chief Executive will establish within the Group Scheme of Delegation appropriate arrangements for the management of in year changes to the capital programme and the provision of appropriate reporting to the Trust Board to support the oversight role. This will include the setting of any value thresholds or other parameters to govern the day to day management of the programme at each Trust.

12.1.4 For capital schemes where the contracts stipulate stage payments, the Chief Financial Officer will issue procedures for their management, incorporating relevant Estates guidance (where appropriate and to the extent that this is not inconsistent with any directions or guidance from the Independent Regulator).

12.1.5 The Chief Financial Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

12.1.6 The approval of a capital programme shall not constitute approval for the initiation of expenditure on any scheme. The right to commit expenditure is subject to the clause at 12.1.7.

12.1.7 The Chief Executive, or the Chief Financial Officer on their behalf, shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender; and

(c) approval to accept a successful tender.

12.1.8 The Chief Executive will issue a Scheme of Delegation for capital investment management in accordance with relevant Estates guidance (where appropriate and to the extent that this is not inconsistent with any directions or guidance from the Independent Regulator) and the Trust's Standing Orders (contained within the Trust Constitution at NLAG).

12.2 Private Finance

12.2.1 When the Trust proposes to use private finance, the following procedures shall apply:

(a) the Chief Financial Officer shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector;

(b) where the sum exceeds the delegated limits set out in the Group Scheme of Delegation, a business case must be prepared and the Trust shall comply with any relevant guidance and/or best practice advice and approval requirements issued by the Independent Regulator; and

(c) the proposal must be specifically agreed by the Board of Directors in the light of such professional advice as should reasonably be sought.

12.3 Asset Registers

12.3.1 The Chief Financial Officer is responsible for the maintenance of registers of assets and for establishing clear procedures concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

12.3.2 Each Trust shall maintain an asset register recording protected property, in accordance with the guidance issued by the Independent Regulator.

12.3.3 The Trusts may not dispose of any protected property without the approval of the Independent Regulator. This includes the disposal of part of the property or granting an interest in it. Where protected property is lost or disposed of, the value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

12.3.4 The Chief Financial Officer shall approve procedures for reconciling balances on protected property accounts in ledgers against balances on protected property asset registers.

12.4 Security of Assets

12.4.1 The overall control of all assets is the responsibility of the Chief Executive, advised by the Chief Financial Officer for the accounting and physical management and control aspects of asset management.

12.4.2 Each Trust has a Security Management Director, who is normally the Director of Estates and Facilities, and a Non-Executive Director at each Trust with overall responsibility for security management at Board level. The operational level officer is the Local Security Management Specialist (LSMS).

12.4.3 Asset control procedures (including protected property, non-protected assets, cash, cheques and negotiable instruments and also including donated assets) must be approved by the Chief Financial Officer. These procedures shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repair and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of and title to assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset; and

(g) the asset replacement policy.

12.4.4 All discrepancies revealed by verification of physical assets to the asset register shall be notified to the Chief Financial Officer who shall decide what further action shall be taken.

12.4.5 Whilst each officer has a responsibility for the security of property of each Trust, it is the responsibility of Directors and all employees to apply appropriate security practices in relation to property of each Trust as may be determined by the Board of Directors. Any breach of agreed security practices must be reported in accordance with Trust policy.

12.4.6 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Directors and officers in accordance with the procedure for reporting losses (See SFI 13 - Disposals and Condemnations, Losses and Special Payments).

12.4.7 Where practical, assets should be marked as relevant Trust property.

13.0 Disposals and Condemnations, Losses and Special Payments

13.1 Disposals and Condemnations

13.1.1 The Chief Financial Officer must prepare detailed procedures, in accordance with the regulatory framework and guidance issued by the Independent Regulator, for the disposal of assets including condemnations, scrap materials and items surplus to requirements and ensure that these are notified to managers. The Trusts may not dispose of any protected property without the approval of the Independent Regulator. These procedures shall comply with all appropriate SOs and SFIs.

13.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine and advise the Chief Financial Officer of the estimated market value of the item, taking account of professional advice where appropriate and the recommended disposal mechanism to adopt (including whether competitive bids should be sought) in order to ensure that best value is achieved. The disposal method will take into account potential risks and reputational impacts.

13.1.3 No officer shall transfer any equipment to a consumer without the prior written authority of the Chief Financial Officer.

13.1.4 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an officer (the condemning officer) authorised for that purpose by the Chief Financial Officer; and

(b) recorded by the condemning officer in a form approved by the Chief Financial Officer, which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second officer authorised for the purpose by the Chief Financial Officer.

13.1.5 The condemning officer shall satisfy him/herself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Financial Officer, who will take the appropriate action.

13.1.6 Authority to condemn plant and equipment shall be in line with the delegated limits set out in Appendix A of the Group Scheme of Delegation.

13.2 Losses and Special Payments

13.2.1 The Chief Financial Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments.

13.2.2 Any officer discovering or suspecting a loss of any kind must immediately inform their Head of Department, who must immediately, or without undue delay depending on the seriousness of the loss, inform the Chief Financial Officer. The Chief Financial Officer will inform the Chief Executive where this demonstrates the potential for further loss or where there is a material impact on the financial performance of the organisation concerned.

13.2.3 For incidents of theft, arson, minor break-ins, etc. the appropriate Site Manager or Security Officer is responsible for informing the LSMS / police (as appropriate) and thereafter the Director of Estates and Facilities. The Chief Financial Officer must be duly notified regarding losses incurred from such acts of criminality. In cases of fraud or corruption or of anomalies that may indicate fraud or corruption, the Chief Financial Officer must immediately inform the LCFS.

13.2.4 The Chief Financial Officer must notify the Trust's External Auditor of all actual frauds against the Trust concerned (this is normally through the Audit, Risk and Governance Committee).

13.2.5 For losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness, except if trivial, the Chief Financial Officer must immediately notify:

(a) the Board of Directors; and

(b) the LCFS (issues of fraud) or LSMS (issues of theft).

13.2.6 For all losses, the Chief Financial Officer shall review the reasons for the loss and take action to address any weaknesses in either Trust systems identified as a result.

13.2.7 For any loss, the Chief Financial Officer, as appropriate, should consider whether any insurance claim can be made.

13.2.8 Within limits delegated to it by the Independent Regulator and HM Treasury, the Board of Directors shall approve the writing-off of losses above the level delegated to nominated Executive Directors or other senior officers, as contained in the Group Scheme of Delegation.

13.2.9 The Chief Financial Officer shall maintain a Losses and Special Payments Register for each Trust in which write-off action is recorded.

13.2.10 Reports of requests for write-off of losses and special payments shall be made routinely to the Audit, Risk and Governance Committee. The minutes of the Audit, Risk and Governance Committee will be reported to the Board of Directors.

13.2.11 No special payments exceeding delegated limits shall be made without prior approval of the Independent regulator/HM Treasury, this includes special severance payments to any member of staff involving non-contractual payments. This shall be in line with Appendix A of the Group Scheme of Delegation. Refer also to Annex 4.13 - Special Payments - in HM Treasury's publication 'Managing Public Money'.

13.2.12 The Chief Financial Officer shall take any necessary steps to safeguard the relevant Trust's interests in bankruptcies and company liquidations.

14.0 Computerised Financial Data Storage and Security

14.1 The Chief Financial Officer, who is responsible for the accuracy and security of the computerised financial data of each Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate protection of each Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Acts and NHS Information Governance requirements;

(b) ensure that adequate controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment; and

(d) ensure that an adequate management audit trail exists through the computerised systems (including those obtained by external agency arrangements) and that such computer audit reviews as he/she may consider necessary are being carried out.

14.2 The Chief Financial Officer shall satisfy him/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, written assurances of adequacy will be obtained from them prior to implementation.

14.3 The Chief Financial Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage. The contract shall also ensure rights of access for audit purposes.

14.4 Where another health organisation or any other agency provides a computer service for financial applications, the Chief Financial Officer shall periodically seek written assurances that adequate controls are in operation.

14.5 Where computer systems have an impact on corporate financial systems, the Chief Financial Officer, in conjunction with the Chief Digital Officer, shall satisfy him/herself that:

(a) systems acquisition, development and maintenance are in line with relevant Trust strategies and policies, such as an Information Technology Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely and that a management (audit) trail exists;

(c) Finance staff have access to such data;

(d) such computer audit reviews as are considered necessary are being carried out; and

(e) any changes to such systems are notified to and approved by the Chief Financial Officer.

14.6 The Chief Digital Officer shall ensure that all computer software held by each Trust is properly licensed and operated in accordance with the terms of the licence.

14.7 The Chief Digital Officer shall ensure that risks to each Trust arising from the use of IT are effectively identified and considered and appropriate action is taken to mitigate or control risk. This shall include the preparation and testing of disaster recovery plans.

14.8 The Chief Digital Officer will devise procedures which ensure that orders for the acquisition of computer hardware, software and services (other than consumables) are placed in accordance with relevant Trust strategies and policies, such as an Information Technology Strategy.

14.9 The Chief Digital Officer will ensure that appropriate control procedures are put in place for computer systems. These procedures will include the arrangements for the acquisition and disposal of IT systems and equipment and the decommissioning of systems containing confidential data. Such procedures will comply with all relevant guidance issued by regulatory bodies. The permanent deletion of IT systems will be approved in line with Appendix A of the Group Scheme of Delegation.

15.0 Patients' Property

15.1 Each Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival. Staff have a duty of care to make every effort to take care of patient's possessions which are **not** handed in for safe keeping, particularly if the patient does not have the capacity to look after their own possessions. This includes items of daily living such as glasses, false teeth, hearing aids, etc.

15.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission of the arrangements for safeguarding property by:

(a) notices and information booklets;

(b) hospital admission documentation and property records; and

(c) the oral advice of administrative and nursing staff responsible for admissions.

This will include the requirement to inform them that the relevant Trust will not accept responsibility or liability for patients' property brought into Trust premises unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

15.3 The Chief Financial Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all officers whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money.

15.4 Where necessary and appropriate, the Chief Financial Officer shall establish suitable arrangements for opening and managing individual bank accounts for money deposited with the relevant Trust for safekeeping by patients, in line with any relevant national guidance.

15.5 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of patients' property and income.

15.6 All staff shall abide by the policies and procedures for managing patients' property and money.

16.0 Funds Held on Trust (Charitable Funds)

16.1 At HUTH, charitable donations are managed by an independent charitable trust – WISHH (Working Independently to Support Hull Hospitals) – registered in England and Wales (1162414). HUTH is represented on the WISHH Board by an Executive Director of the Trust.

16.2 At NLAG the following sections shall apply:

16.3 NLAG has defined financial responsibilities as a corporate trustee for the management of funds held on trust. The discharge of these responsibilities is distinct from the management arrangements for the Trust's exchequer funding but must adhere to the overriding principles of financial regularity, prudence and propriety.

16.4 NLAG has a Charitable Funds Committee, known as the Health Tree Foundation Trustees Committee, with approved Membership and Terms of Reference, which is responsible for overseeing the management of the affairs of the Trust's Charitable Funds. The Committee reports directly to the Trust Board, but is designed to be independent in its decision making. The working name of the Trust's Charitable Funds is The Health Tree Foundation.

16.5 The Chief Financial Officer shall establish procedures to manage all funds held on trust. This will include ensuring compliance with Charity Commission and other relevant best practice guidance. Procedure notes for fund managers can be found on the Trust intranet.

16.6 Unless specific regulatory requirements to the contrary exist, these SFIs will fully apply to the management of funds held on trust.

16.7 NLAG's Charitable Funds accounts will be subject to annual external audit.

17.0 Risk Management and Insurance

17.1 The Chief Executive shall ensure that each Trust has a programme of risk management in accordance with the current directions and guidance in relation to assurance frameworks as issued by the Independent Regulator, which must be approved and monitored by the Board of Directors.

17.2 The programme of risk management shall include:

(a) a process for identifying and quantifying risks and potential liabilities;

(b) engendering among all levels of staff a positive attitude towards the control of risk;

(c) management processes to ensure that all significant risks and potential liabilities are addressed, including effective systems of internal control, cost effective insurance cover and decisions on the acceptable level of retained risk;

(d) contingency plans to offset the impact of adverse events;

(e) audit arrangements, including internal audit, clinical audit and health and safety review;

(f) arrangements to review the risk management programme; and

(g) decisions on which risks shall be insured through arrangements with either the NHS Resolution Pooling Schemes or commercial insurers, in line with the Group Scheme of Delegation;

17.3 The existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of internal control within each Trust's annual report and accounts, as required by the Independent Regulator's guidance.

17.4 The Director of Assurance, Chief Financial Officer and Chief Medical Officer shall be responsible for ensuring that adequate insurance cover is effected in accordance with the risk management policy approved by each Board of Directors.

17.5 Each officer shall promptly notify the Director of Assurance of all new risks or property under his/her control which require insurance and of any alterations affecting existing risks or insurances. The information held on the relevant Trust's Risk Register will be used to inform the Trust of any changes needed to existing insurance policies.

17.6 The Director of Assurance shall ascertain the amount of cover required and shall effect such insurances as are necessary to protect the interests of the Trusts.

17.7 The Chief Executive or the Chief Financial Officer shall make all claims arising out of policies of insurance and each officer shall furnish the Chief Financial Officer immediately with full particulars of any occurrence involving actual or potential loss to the relevant Trust and an estimate of the probable cost involved.

17.8 The Director of Estates and Facilities shall ensure that all engineering plant under his/her control is inspected by the relevant insurance companies within the periods prescribed by legislation.

17.9 The value of all assets and risks insured shall be reviewed or index-linked on an annual basis by the designated officer.

17.10 Where the NHS Resolution Risk Pooling Schemes are used, the Director of Assurance, Chief Financial Officer and Chief Medical Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme for each Trust.

17.11 The Chief Financial Officer shall ensure that documented procedures cover the management of claims and payments in respect of all insurance arrangements, including the management of excesses payable by each Trust.

17.12 If an income generation activity is also an activity normally carried out by the relevant Trust for a NHS purpose, the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from NHS Resolution. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements, the Chief Financial Officer should consult NHS Resolution.

18.0 Standards of Business Conduct

18.1 General

18.1.1 A policy on Standards of Business Conduct shall be approved by the Audit, Risk and Governance Committee and made available to staff. The Trust's Standards of Business Conduct Policy (NLAG) / Declaring Gifts and External Interests Policy (HUTH), and associated procedures/declaration forms, are designed to ensure that Trust staff working within the Group maintain the highest standard of public accountability and are open and honest in their NHS business conduct.

18.1.2 The policies referred to in 18.1.1 deal with accepting gifts, hospitality and sponsorship; employee's declarations of interest and secondary employment.

18.2 Acceptance of Gifts and Hospitality

18.2.1 The Bribery Act 2010, which came into effect on 1 July 2011, makes it a criminal offence to give, promise or offer a bribe and to request, agree to receive or accept a bribe, either at home or abroad. The Bribery Act 2010 shall have effect as if incorporated into these SFIs.

18.2.2 All officers shall declare any offer of hospitality or gifts, whether accepted or declined, in line with the Standards of Business Conduct Policy (HUTH) / Declaring Gifts and External Interests Policy (HUTH). The Director of Assurance will maintain a register of hospitality and gifts for each Trust, as notified to him/her and this will be reported routinely to the Audit, Risk and Governance Committee for review.

18.2.3 The Director of Assurance shall ensure that all officers are made aware of each Trusts policy on acceptance of gifts, hospitality and other benefits in kind.

18.3 Private Transactions

18.3.1 Officers having official dealings with contractors or other suppliers of goods or services should avoid transacting any kind of private business with them by means other than normal commercial channels. No favour or preference with regard to price or otherwise which is not generally available should be sought or accepted. Refer also to section 18.2.1 above regarding the requirements of the Bribery Act 2010.

18.4 Declaration of Interests

18.4.1 The Trust Constitution (NLAG) / SO's (HUTH) refers to the regulatory framework requirement for Board Directors and NLAG Governors to formally declare interests that are relevant and material to the NHS Trust Board or Council of Governors (NLAG only) of which they are a member. It also gives examples of 'relevant and material' interests.

18.4.2 In accordance with the Trust Constitution (NLAG) and SO's (HUTH), the Director of Assurance shall be advised of declared pecuniary interests of members of the Board of Directors and Governors (NLAG only) for recording in the relevant Register of Interests, which the Director of Assurance will maintain for that purpose. The declaration form contained within the Trust's Standards of Business Conduct Policy (NLAG) / Declaring Gifts and External Interests Policy (HUTH) shall be used for the Board of Directors and NLAG Governors to make such declarations.

18.4.3 For all other employees any such interests shall be declared to the Director of Assurance in line with the Standards of Business Conduct Policy (NLAG) / Declaring Gifts and External Interests Policy (HUTH) and the associated declaration forms.

18.4.4 Declarations of interest will be reported routinely to the Audit, Risk and Governance Committee for review. Additionally, registers of such interests will be submitted to public meetings of the Trust Board (for Board members and all other Trust employees) and the NLAG Council of Governors (for NLAG Governors interests).

18.5 Intellectual Property (IP)

18.5.1 Refer to the Trust's Policy on Intellectual Property. Also see Appendix A of the Group Scheme of Delegation.

19.0 Retention of Documents

19.1 The Chief Executive shall be responsible for defining retention periods and maintaining archives for all documents required to be retained, in accordance with guidance from the Independent Regulator and/or the DHSC or any other statutory requirements.

19.2 The documents held in archives shall be capable of retrieval by authorised persons.

19.3 All documents shall be held for the required retention periods in line with guidance from the Independent Regulator, the DHSC and local policies on the preservation, retention and destruction of documents.

19.4 Documents held in accordance with the latest Independent Regulator (and where applicable DHSC) guidance shall only be destroyed in accordance with procedures specified by the Chief Executive. Records shall be maintained of documents so destroyed.

The electronic master copy of this document is held by Document Control, Directorate of Assurance, NHS Humber Health Partnership.

Appendix A

Standing Orders in relation to Tendering and Contracting Procedures

1. Duty to Comply with Standing Orders

The procedure for making all contracts by or on behalf of each Trust shall comply with these Standing Orders (except where the Suspension of SOs (contained within the Trust Constitution at NLAG) is applied). Failure to comply will be treated as a disciplinary matter.

2. EU Directives Governing Public Procurement

Directives by the UK Government on public sector purchasing as brought into effect in England by Act of Parliament and statutory instrument shall have effect as if incorporated in these Standing Orders.

3. Compliance with Guidance

Each Trust shall comply as far as is practicable and relevant with the requirements of "Estatecode" in respect of capital investment and estate and property transactions and with the DHSC guidance. In the case of management and consultancy contracts the trust shall comply as far as is practicable with relevant DHSC and Independent Regulator guidance.

4. Formal Competitive Tendering

4.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided under contract or in-house. The Board may determine from time to time that in-house services should be market tested by competitive tendering (section 12 refers).

4.2 Each Trust shall ensure that competitive tenders are invited for the following, in line with the authority levels for obtaining tenders (and quotations) as set out in Appendix A of the Group Scheme of Delegation:

(a) the supply of goods, materials and manufactured articles;

(b) the rendering of any services including all forms of management consultancy;

(c) the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and

(d) disposals / sale of assets.

4.3 It is a breach of regulations to split contracts to avoid appropriate tendering / quotation thresholds. The value used should be the overall contract value for the life of the equipment or service not annual costs, and including VAT.

4.4 For waiving of formal tendering requirements refer to section 10.

4.5 Each Trust shall ensure that requirements are tendered openly in a clear and transparent manner or procured via approved framework agreements. Use of approved frameworks must be in line with the requirements of the framework. Any use of frameworks which is not in line with the stated award process, should be justified with a waiver.

5. Invitation to Tender (E-Tendering)

5.1 **Electronic Tendering** - All invitations to tender will be on a formal competitive basis applying the principles set out below using the Trusts e-tendering Portal.

5.2 All tendering carried out through e-tendering will be compliant with the Trusts policies and procedures relating to tendering as set out below. The issue of all tender documentation will be undertaken electronically through a secure website with controlled access using secure login, authentication and viewing rules. All tenders will be received into a secure electronic location so that they cannot be accessed until an agreed opening time. Where the electronic tendering package is used the details of the officer opening the electronic documents will be recorded in an audit trail together with the date and time of the document opening. All actions and communication by both Procurement staff and suppliers are recorded with the system audit reports.

5.3 Every tender for goods, materials, manufactured articles supplied as part of a works contract and services shall embody such of the main contract conditions as may be appropriate in accordance with the contract forms described in section 5.5 and 5.6 below.

5.4 Every tender for building and engineering works, shall embody or be in the terms of the current edition of the appropriate Joint Contracts Tribunal (JCT) or New Engineering Contract (NEC) form of contract amended to comply with Concode. When the content of the works is primarily engineering, tenders shall embody or be in the terms of the General Conditions of Contract recommended by the Institutions of Mechanical Engineers and the Association of Consulting Engineers (Form A) or, in the case of civil engineering work, the General Conditions of Contract recommended by the Institution of Civil Engineers. The standard documents should be amended to comply with Concode and, in minor respects, to cover special features of individual projects.

5.5 Every tender for goods, materials, services (including consultancy services) or disposals shall embody the Standard Contract Terms and Conditions as are applicable (e.g., NHS or Cabinet Office). Every tenderer must have given a written undertaking not to engage in collusive tendering or other restrictive practice.

5.6 For every invitation to tender for services the Director of Procurement must be satisfied as to the financial standing, and the relevant requisitioner satisfied as to the technical/clinical competence of the provider.

6. Receipt, Safe Custody and Record of Formal Tenders (E-Tendering)

6.1 Formal competitive tenders shall be submitted via the Trusts e-tendering portal.

6.2 The Chief Financial Officer shall ensure that appropriate security arrangements are in place to receive tenders electronically, and that the system will register the tenders with the date and time received, but will not allow opening until the tender close date and time.

6.3 The date and time of receipt of each tender shall be logged on the e-tendering system.

6.4 Tenders shall be opened by the Procurement lead for the project using the appropriate system access logins.

7. Opening Formal Tenders (E-Tendering)

7.1 As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by the Procurement lead in accordance with the agreed policy.

7.2 Every tender received shall be recorded electronically within the e-tendering system.

7.3 A permanent record shall be maintained to show for each set of competitive tender invitations despatched:

(a) the names of firms/individuals invited;

(b) the names of and the number of firms/individuals from which tenders have been received;

(c) the total price(s) tendered;

(d) closing date and time;

(e) date and time of opening; and the persons present at the opening shall sign the record.

7.4 Except as in section 7.5 below, a record shall be maintained of all price alterations on tenders, i.e., where a price has apparently been altered, and the final price shown shall be recorded. Every price alteration appearing on a tender and the record should be recorded through the e-tendering system.

7.5 A report shall be made in the record if, on any one tender, price alterations are so numerous as to render the procedure at section 7.4 unreasonable.

7.6 The tender documents will then be shown to the director or their nominated officer of the originating department for confirmation.

8. Admissibility and Acceptance of Formal Tenders

8.1 In considering which tender to accept, if any, the designated officers shall have regard to whether value for money will be obtained by the trust, taking into account whole lifetime costs, and whether the number of tenders received provides adequate competition. In cases of doubt they shall consult the Chief Executive or Chief Financial Officer.

8.2 Tenders received after the due time and date may be considered only if the Chief Executive or nominated officer decides that there are exceptional circumstances, (e.g., where significant financial, technical or delivery advantages would accrue), and is satisfied that there is no reason to doubt the bona fides of the tenders concerned. The Chief Executive or nominated officer shall decide whether such tenders are admissible and whether re-tendering is desirable. Re-tendering may be limited to those tenders reasonably in the field of consideration in the original competition. If the tender is accepted the late arrival of the tender should be reported to the Board at its next meeting.

8.3 Materially incomplete tenders (i.e., those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e., those amended by the tenderer upon his/her own initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders under section 9.2.

8.4 Where examination of tenders reveals errors or a need for clarification that would affect the tender figure, the tenderer is to be given details of such errors/clarifications and afforded the opportunity of confirming or withdrawing his/her offer.

8.5 Necessary discussions with a tenderer of the contents of his/her tender, in order to elucidate technical points etc., before the award of a contract, need not disqualify the tender.

8.6 While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration and while re-tenders are being obtained, the tender documents shall remain strictly confidential and kept in safekeeping by an officer designated by the Chief Executive.

8.7 Where only one tender/quotation is received the Trust concerned shall, as far as practicable, ensure that the price to be paid is fair and reasonable.

8.8 All tenders shall be evaluated on the basis of MAT (Most Advantageous Tender) and in conjunction with the published award criteria and weightings.

8.9 A tender other than the most advantageous tender (MAT) shall not be accepted unless there are good and sufficient reasons permanently recorded and approved by the Director of Procurement, Chief Financial Officer **and** the Chief Executive.

8.10 Where the form of contract includes a fluctuation clause all applications for price variations must be submitted in writing by the tenderer and shall be approved by the Chief Financial Officer or nominated officer.

8.11 All tenders should be treated as confidential and should be retained for inspection.

9. Delegated Limits for Award

9.1 Formal tenders/quotations may be awarded as detailed in Appendix A of the Group Scheme of Delegation.

10. Waiving of Formal Tendering Procedures

10.1 In exceptional circumstances it may be impractical to follow the quotation or tendering process. If so a request for waiver of Standing Financial Instructions (SFIs) (relating to quotations and tenders) must be completed.

10.2 The reason for waiving competitive tendering procedures under this Standing Order shall be documented in a permanent record and approved, before any order may be placed or any financial commitment entered into, by the Director of Procurement or Chief Financial Officer (in the absence of either the Director of Procurement or Chief Financial Officer, and the need for urgency, the Chief Executive shall perform the authorisation function. In cases where the Chief Executive is on annual leave this would be the Acting Chief Executive. In cases where the Chief Executive is off site and there is a need for urgency in signing the waiver in the absence of the Director of Procurement or Chief Financial Officer, the Chief Executive will formally nominate in writing via email a Deputy to act on his/her behalf for that specific purpose).

10.3 All waivers must be completed prospectively.

10.4 All officers must comply with the waiver procedure where necessary. The waiver procedure can be found on the Trust intranet (and a main extract is reproduced at Appendix B of these SFIs).

10.5 If any officer is uncertain about the relevant Trust's tendering and quotation requirements or the waiver procedure they must contact the Trust's Procurement team for advice and guidance.

10.6 Failure to plan the work properly and as a result be time restricted is not a justification for waiver. Such instances will be recorded as non-compliant and reported to the Audit, Risk and Governance Committee.

10.7 All waivers will be reported to the Audit, Risk and Governance Committee for oversight and scrutiny purposes.

10.8 Formal quotation or tendering procedures may be waived where:

(a) Chief Executive Directive - The CEO understands the risk of non-compliance but issues directive (with the agreement of the CFO) to proceed due to organisational need; or

(b) Continuity of Service - Where services/ works have commenced with one supplier and it would be economically unviable to change suppliers; or

(c) Legal Advice - Due to the nature of the legal advice required the Trust concerned is unable to select through competition the legal firm spend occurs with; or

(d) Nationally Funded Programme - National funding comes with a directive that a specific supplier is used; or

(e) Only Supplier - It can be evidenced that there is only one supplier who is able to provide the goods, services or works such as maintenance undertaken by the Original Equipment Manufacturer (OEM) to maintain the warranty; or,

(f) Standardisation - When for Clinical/Operational reasons it is deemed appropriate to standardise on a particular product; or

(g) Urgent Requirement - Where timescales preclude a competitive process but a failure to plan is not regarded as a justification.

11. Procurement of Consultancy Services

11.1 The Regulators have issued specific guidance setting out expenditure delegation limits for individual organisations and requiring central Regulator approval for all consultancy engagements above a certain value. All Trust budget holders within the Group must follow the latest iteration of this guidance whenever procuring consultancy services.

11.2 For consultancy engagements below the latest Regulator guidance the rules in these SFI's apply.

12. In-House Services

12.1 In all cases where the Trust concerned determines that in-house services should be subject to competitive tendering, or outsourced services should be brought back in-house, the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer(s) and specialist(s).

(b) In-house tender group, comprising representatives of the in-house team, a nominee of the Chief Executive and technical support;

(c) Evaluation group, comprising normally a specialist officer, a supplies officer and a Chief Financial Officer representative. For services having a likely annual expenditure exceeding £1,000,000, a non-executive director will be a member of the evaluation team.

12.2 All groups should work independently of each other but individual officers may be members of more than one group. No member of the in-house tender group may, however, participate in the evaluation of tenders.

12.3 The evaluation group shall make recommendations to the Board.

12.4 The Chief Executive shall nominate an officer to oversee and manage the contract.

13. Contracts

13.1 Each Trust may only enter into contracts within its statutory powers and shall comply with:

- these Standing Orders;
- the Group SFIs;
- The Procurement Act;
- any relevant NHSE guidance on the Procurement and Management of Consultants.

Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

In all contracts made by either Trust, the Board shall endeavour to obtain best value for money. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust concerned. Contracts shall be signed in line with Appendix A of the Group Scheme of Delegation.

14. Personnel and Agency or Temporary Staff Contracts

The Chief Executive shall nominate officers with delegated authority to enter into contracts for the employment of other officers, to authorise the regrading of staff, and enter into contracts for the employment of agency staff or temporary staff. Refer to Appendix A of the Group Scheme of Delegation.

15. Cancellation of Contracts

Every written contract shall include standard clauses empowering the Trust concerned to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancellation under the circumstances stated in the standard contract or relevant framework contract documentation.

16. Contracts Involving Funds Held on Trust

Such contracts involving charitable funds shall comply with the requirements of the Charities Acts.

17. Disposals

Competitive tendering or quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his/her nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trusts;

(c) items to be disposed of with an estimated sale value of less than £5,000, this figure to be reviewed annually;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which guidance has been issued by the independent regulator, but subject to compliance with such guidance

Condemning and disposal of plant and equipment shall however be authorised in line with Appendix A of the Group Scheme of Delegation.

Appendix B

WAIVER PROCEDURE

1.0 Purpose

1.1 In exceptional circumstances it may be impractical to follow the quotation or tendering process. If so a request for waiver of Standing Financial Instructions (SFIs) (relating to quotations and tenders) must be completed and authorised by the relevant Director, before being submitted to the Director of Procurement for review / approval or recommendation to the Chief Financial Officer depending upon value.

1.2 The purpose of this document is to outline the process required to complete a waiver for the justification for non-compliance with the Group SFIs and Standing Orders (SOs) during the procurement of goods and services.

2.0 Area

Trustwide for any staff involved in the selection and procurement of goods and services on behalf of the Group.

3.0 Duties

Any requests for goods/services which do not comply with Group Standing Orders/SFIs must be accompanied by an appropriately completed Waiver Form (see below) which is available as a standalone document for completion on the Trust intranet titled Waiver Form.

4.0 Actions

4.1 Any requisition received which does not comply with Group Standing Orders/SFIs should be returned to the Requestor by the Procurement Officer concerned. When returning a requisition to the Requestor an appropriate explanation for its return should always be provided.

4.2 Standing Financial Instruction Thresholds (SFIs) for Ordering of Goods & Services:

Value of Expenditure	Authority Delegated to / Quotation & Tendering requirements
For details of the quotation and tendering requirements and associated financial limits refer to Appendix A of the Group Scheme of Delegation.	

4.3 Step by Step Guide to completing a Waiver Form:

- **Step 1:** Speak to your Procurement Business Partner to see whether a waiver needs to be completed.

- **Step 2:** Sections 2 and 3 must be completed by the Requestor, stating the nature of the procurement and clearly detailing the justification for non-compliance with Group SFI's/SOs. To facilitate faster processing the completed waiver should be accompanied by the official Trust purchase requisition and copies of any relevant supporting paperwork such as quotes, clinical justifications, business cases, committee reports, etc

- **Step 3:** The requestor or authorised officer responsible must also sign section 3 and obtain an approval signature from the appropriate Director. It should be noted that the official Trust purchase requisition still requires the correct authorisation/signatures according to value and cost centre, regardless of the signatures that appear on the waiver form itself

- **Step 4:** Once authorised by the appropriate Director the original waiver form, purchase requisition and supporting documentation must be sent to the Procurement Business Partner for completion of section 4. Where the Procurement Business Partner is absent due to annual leave or sickness and the waiver matter is urgent, the Assistant Procurement Business Partner will deputise where possible and complete in line with the established process

- The Procurement Team will, if appropriate, check the requirement against any local contract arrangements, National or Regional Contracts/Framework Agreements to ensure there are no conflicts of interest with existing contracts or supply arrangements.

- The Director of Procurement will provide the justification for waiving the Standing Orders as one of the following categories, based on the information received and subject to further clarification (where necessary):

  (a) Chief Executive Directive (with agreement of CFO also)

  (b) Continuity of Service

  (c) Legal Advice

  (d) Nationally Funded Programme

  (e) Only Supplier

  (f) Standardisation

  (g) Urgent Requirement

- **Step 5:** If the Director of Procurement is satisfied that the request for a waiver is justified on procurement grounds the waiver form will be signed as evidence of this by the Director of Procurement

- **Step 6:** All waivers must then be forwarded to and authorised by the Director of Procurement or Chief Financial Officer (depending upon value) before an order may be placed or financial commitment entered into. For waivers where

the Chief Financial Officer is the relevant Director at Step 2, then these will be authorised by the Chief Executive

(In the absence of either the Director of Procurement or Chief Financial Officer, and the need for urgency, the Chief Executive shall perform the authorisation function. In cases where the Chief Executive is on annual leave this would be the Acting Chief Executive. In cases where the Chief Executive is off site and there is a need for urgency in signing the waiver in the absence of the Director of Procurement or Chief Financial Officer, the Chief Executive will formally nominate in writing via email a Deputy to act on his/her behalf for that specific purpose)

- **Step 7:** Once the relevant authorisation has been provided the Waiver form is returned to the Procurement Team for order processing and completion of section 5

- **Step 8:** A report detailing the waivered transactions shall also be compiled on behalf of the Chief Financial Officer for submission bi-annually to of the Trust's Audit, Risk and Governance Committee for oversight and scrutiny

- Original Waiver forms shall be retained in line with the Trust's document retention policy

5.0 Monitoring Compliance and Effectiveness

A schedule of all authorised requests for waivers shall be maintained by the Procurement Department to facilitate compilation of a report detailing the waivered transactions for submission to the Trust's Audit, Risk and Governance Committee. Instances of non-compliance with the waiver procedure shall be brought to the attention of the Audit, Risk and Governance Committee (at the next available meeting) as and when they arise.

Definitions

Non-compliance with Standing Orders/Adverse impact on Trust Operations (if not approved) – This occurs where a department has not followed the correct procurement processes, but it is not within the relevant Trust's operational interests to block the procurement process.

Standardisation – This occurs where a strategic decision is made to choose a supplier's products or services which are already in use within the relevant Trust, creating a consistent approach across all Trust areas. This may occur where there are clear clinical benefits to using the same equipment, for example where cross-site staffing is in place.

Maintenance Agreement – The purchase of maintenance contracts should be completed when equipment is purchased to ensure value for money for the relevant Trust rather than purchasing maintenance post equipment purchase.

Rejection of Lowest Tender – This occurs where a procurement process has been followed, but the lowest value offer is not the favoured solution. The procurement methodology of most advantageous tender (MAT) will have been followed to identify the most suitable solution.

NHS HUMBER HEALTH PARTNERSHIP

REQUEST FOR WAIVER OF STANDING ORDER/STANDING FINANCIAL INSTRUCTIONS

Section 1: NOTES

1.1 This form is to be completed in all circumstances where the competitive quotation/tendering procedures required under the Trust's Standing Orders (SO) are to be waived. The Waiver procedure is available on the Trust intranet. It should be noted the Trust cannot waive Procurement law.

1.2 All sections of the form up to and including Section 3 must be completed in full by the requisitioning officer before submitting for approval to the appropriate Director. Particular emphasis must be given to giving comprehensive details which justify why Standing Orders should be waived. The Director approved waiver form should then be forwarded to the Procurement Department.

All waivers are submitted to the Trust's Audit, Risk and Governance Committee for information.

Section 2: DETAILS OF REQUEST

Trust _____

Department _____ Division _____ Source of Funding _____

Description of Goods or Services Requested:

_____
_____
_____
_____

Purchase Value (£) _____ VAT(£) _____ Total Value(£) _____

Proposed Supplier _____ Contract Period _____ Confirmation no conflict of interest _____

Section 3: JUSTIFICATION FOR WAIVING STANDING ORDERS:

I request that Standing Orders are waived for this item of expenditure because:

a)	Chief Executive Directive - The CEO understands the risk of non-compliance but issues directive to proceed due to organisational need. Requires CFO agreement also.	
b)	Continuity of Service - Where services/ works have commenced with one supplier and it would be economically unviable to change suppliers.	
c)	Legal Advice - Due to the nature of the legal advice required the Trust is unable to select through competition the legal firm spend occurs with.	
d)	Nationally Funded Programme - National funding comes with a directive that a specific supplier is used.	
e)	Only Supplier - It can be evidenced that there is only one supplier who is able to provide the goods, services or works such as maintenance undertaken by the Original Equipment Manufacturer (OEM) to maintain the warranty.	
f)	Standardisation - When for Clinical/Operational reasons it is deemed appropriate to standardise on a particular product.	
g)	Urgent Requirement - Where timescales preclude a competitive process but a failure to plan is not regarded as a justification.	

Further details:

_____
_____
_____
_____
_____

Waiver Requestor's name _____**Requestors Signature** _____ Date ____ / ____ / ____

Director Approval

Director's Name _____ **Director's Signature** _____ Date ____ / ____ / ____

Finance Approval

Finance's Name _____ **Finance's Signature** _____ Date ____ / ____ / ____

Procurement Business Partner Approval

PBPs's Name _____ **PBPs's Signature** _____ Date ____ / ____ / ____

Section 4: DIRECTOR OF PROCUREMENT'S RECOMMENDATION:

_____
_____
_____
_____
_____

DoP Signature _____ Date ___/ ___/ _____

Quotation Waiver	Up to £74,999	
Tender Waiver	£75,000 – Procurement Threshold	
Non-Compliant Paper	Above Procurement Threshold	

Where total contract spend is below Procurement threshold, has previously been approved for Capital Equipment or is maintenance with using NHS Supply Chain or through the original equipment manufacturer:

Director of Procurement (DoP) Approval _____ Date ___ / ___ / _____

Where total contract spend is above the Procurement threshold and below £500,000 inc. VAT

Chief Financial Officer (CFO) Approval _____ Date ___ / ___ / _____

Where the CFO is the relevant Director at Section 2 above or in the absence of the CFO, the CEO shall perform the authorisation function:

CEO Approval _____ Date ___ / ___ / _____
See the waiver procedure for what to do in the absence of both the CFO and the CEO.

Where total contract spend is above £500,000 and below £2,500,000:

Cabinet Approval _____ Date ___ / ___ / _____

Where total contract spend is above £2,500,000:

Trust Board Approval _____ Date ___ / ___ / _____

Section 5: FOR PROCUREMENT USE ONLY

Order/ Contract Number _____ Date ___ / ___ / _____ Supplier _____

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)153

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**8 August 2024**
Director Lead	**Ivan McConnell, Group Chief Strategy & Partnerships Officer**
Contact Officer / Author	**Linsay Cunningham, Group Deputy Director Strategy & Partnerships**
Title of Report	**Group Strategic Framework 2024 - 2029**
Executive Summary	Over a 14-week period (from April to July 2024), a comprehensive engagement process was undertaken to develop a strategic framework for the group. The engagement process involved around 1600 people in total, through workshops, 1:1 conversation and an online questionnaire. Staff from both trusts, patients, the public and a wide range of external stakeholders took part to share their views and aspirations for the group. Based on this engagement, a strategic framework was developed which sets out the group's ambitions: • Excellent Care • Healthier Communities These ambitions will be focused on four key pillars: • Equity • Partnerships • Innovation • Care And delivered through strategic actions aligned to five key themes: • People • Performance • Quality and Safety • Research and Innovation • Partnerships The Strategic Framework sets out the approach the group will take to deliver its ambitions, focusing initially on laying the foundations to enable transformation and delivery of excellent care and healthier communities.
Background Information and/or Supporting Document(s) (if applicable)	**Strategic Direction – A Journey to Excellence**
Prior Approval Process	Trust Board Development Day – 2 July 2024 The document was co-produced through extensive engagement with Cabinet and Board members

Financial Implication(s) (if applicable)	N/A The strategic framework will support future prioritisation of resources to deliver against the group strategic direction.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	The strategic framework sets out bold ambitions for the group to address health inequalities within the Humber region and support and enable our population to live more years in good health. Implementing the strategic framework across the group will necessitate a shift to a focus on equity – delivering better outcomes for those facing the biggest health inequalities through more targeted interventions and bespoke ways of working.
Recommended action(s) required	✓ Approval ☐ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

NHS
Humber Health
Partnership

Our Strategic Direction – A Journey to Excellence

Strategy Launch – 19/07/24

Ivan McConnell
Linsay Cunningham

Who are we?

NHS Humber Health Partnership

The NHS Humber Health Partnership (HHP) was formally created in April 2024. The Partnership brings together the two biggest NHS organisations in the Humber region:

- Hull University Teaching Hospitals NHS Trust
- Northern Lincolnshire and Goole NHS Foundation Trust

United by Compassion: Driving for Excellence

We care about our people, places, communities: ***We want the best*** for our people, places, communities

Every hour of every day we welcome a new life into the world; every other minute a new patient comes through the door of one of our Emergency Departments; and each year we provide the equivalent of one outpatient appointment for every person in the Humber. We employ over 18,000 people across our group – two times the population of Immingham – and have around 600 regular volunteers.

8,700 Births

122,644 Unplanned Admissions

301,535 A&E Attendances

135,053 Day case operations

1,225,329 Outpatient Appointments

On 1st April 2024, the group implemented a new structure – the first of its kind for any hospital group across the NHS. Putting in place 14 care groups that span both banks of the Humber estuary, we have brought together the talents, skills, ideas, and commitment of our people from both organisations to drive improvement, eliminate inconsistency and deliver change.

Now is the time to set out our collective vision and ambition for the future.

This document sets the strategic direction for our new group. It reflects our commitment to our people and our communities – to providing the best possible care and making a positive and lasting impact in our communities, going beyond the direct impact of our treatments and support.

What we are proud of

Humber Health Partnership

We care about our people, places and communities – we are ***United by Compassion***
We want the best for our people, places and communities – we are ***Driving for Excellence***

We have a long and proud history of serving the Humber region and caring for its people. Our teams consistently go above and beyond to ensure those in our care get the best outcomes and feel safe and well looked after.

In everything that we do, we are led by our values. Our values will define our journey to excellence.

Our values

Compassion	We care. We want the best for our people, places and communities.
Honesty	We are honest about our shortcomings and always strive for better.
Respect	We recognise and respect everyone's unique contribution.
Teamwork	We work together to achieve the best for our patients and communities.

We have much to be proud of

At Humber Health Partnership, we are proud to make a difference in the lives of our patients and communities every day. We are proud of our creativity, dedication and sense of humour. We know our communities really well and care about doing our best for them.

Where are we now?

Our current models of care are struggling to meet existing demand and are not set up to do so in the future. Our population is less healthy than in other parts of the country and as a result people in our communities live many more years in poor health.

Organisational Challenges

Buildings

It would take more than £200 million to bring all our existing buildings up to standard and more than £100 million over the next 15 years to meet anticipated future demand.

Digital Infrastructure

Many of our digital systems are outdated and they do not talk to one other.

Performance

Too many people are waiting too long for diagnosis, care and treatment and staying in hospital longer than is necessary.

Financial sustainability

There is insufficient funding in the system for us to continue as we are.

Population Health Challenges

Deprivation

Much of the Humber's population lives in poverty. In Hull more than 1 in 2 live in the most deprived neighbourhoods and in North East Lincolnshire it is 4 in every 10.

Ageing

The number of over 75-year-olds in our population is increasing and will more than treble in the next 20 years. At the same time, our working age population is shrinking.

Burden of Disease

Women in the Humber will spend, on average, up to 26 years in ill-health and men up to 23 years.

Health Inequalities

People living in the more affluent areas of the Humber can expect to live for up to 13 years longer than those living in the poorest areas.

By coming together as a group, we can work on a much broader scale, we can use the assets we have differently and radically re-imagine how we provide care. By working together in new ways, we can do more to support our population to live healthier, happier lives.

Where are we trying to get to?

We have come together as a group because we care about our people, places and communities. We recognise that we are stronger together and can do more by sharing resources, skills and knowledge.

Our primary role is to provide high-quality healthcare services – our ambition is to provide **excellent care** that meets our population's needs. We also have a wider role to play in our communities and our local population. Our scale and our reach mean we can influence health and wellbeing far beyond the impact of our healthcare services alone. Our ambition is to build **healthier communities** by supporting and enabling our population to live more years in good health.

Our vision of **Excellent Care** and **Healthier Communities** is built on four key pillars – Equity, Partnerships, Innovation and Care. These describe the destination we are driving towards.

	Equity	Partnerships	Innovation	Care
Excellent Care looks like…	We deliver care that meets the needs of those living in the most deprived communities and those facing the biggest barriers (*Core20+5).	We have strong and wide-ranging academic and industry partnerships and trusted relationships across our local health and care systems.	We have a radically different model of care underpinned by effective digital, data and technology, which enables many more people to access the support they need remotely.	We provide high quality local services through our network of (District General) hospitals for all our communities and outstanding specialist services through our elective and tertiary Centre for Excellence (CHH).
	Equity is at the heart of everything we do.	**We work in partnership, not alone.**	**We are agile, we learn, and we improve.**	**First and foremost, we care.**
Healthier Communities looks like…	We improve the life chances of those living in the most deprived communities and facing the biggest barriers through supported employment, access to support for health improvement and good secondary prevention.	We have trusted relationships with our local population and together we are committed to achieving better health.	We work with partners to deliver ground-breaking research on the wider determinants of health to find new ways to improve the health and life chances of people living in rural and coastal regions.	We make every interaction we have – with a patient, carer, friend, colleague – count, seeing it as an opportunity to make a positive impact on their health and wellbeing.

Our Strategic Framework on a page

United by Compassion – Driving for Excellence

Our Ambition is	Led by our values	Focused on four pillars	Delivered through	Underpinned by	Delivering excellence
Excellent care To provide excellent care that meets our population's diverse needs.	Compassion	Equity	People	Digital innovation and digital inclusion	Our people feel proud to work here
	Honesty	Partnerships	Performance		Patients get the best care
Healthier communities To support and enable our population to live more years in good health.	Respect	Innovation	Quality and Safety	Leadership capacity and capability	Local people live more years in good health
	Teamwork	Care	Research and Innovation	Culture for success	We are recognised as leaders in our field
			Partnerships		Our communities feel proud of what we offer

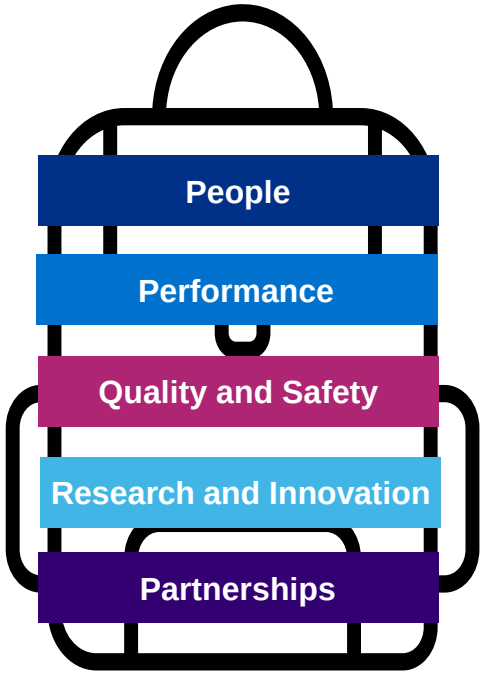
Excellent care

Healthier communities

Working together with our population, our partners, and our people.

How will we get there…?
Our journey to excellence

We have a long way to go to deliver our ambitions of **Excellent Care** and **Healthier Communities**. This will be a difficult journey – we must change expectations, mindsets, culture, and long-standing ways of working. But it will be a journey worth taking – we have an opportunity, with the size, scale, and networks we have, to radically re-imagine the future of health and healthcare in the Humber.



Excellent Care
Healthier Communities

Lay the foundations

- Supporting our teams today
- Eliminating waste and duplication
- Listening to our patients and keeping them safe
- Developing research infrastructure and embedding innovation
- Playing an active role in our health and care system

Excellent Care
Healthier Communities

Transform

- Building a more flexible, adaptable and resilient workforce for tomorrow
- Radically re-imagining how and where we deliver care
- Transforming our services so they are built around the needs of those who use them
- Maximising the impact of research and innovation by aligning our expertise to the big challenges facing our population
- Expanding our influence and building new collaborative arrangements that will enable us to thrive

Excellent Care
Healthier Communities

Deliver

- **Our teams feel proud of what they do and are supported to live healthy lives.**
- **We are the best at what we do and our population gets good outcomes.**
- **Our services flex to meet different needs and local people live more years in good health.**
- **We are recognised as leaders in our field and use our influence to advocate for better health for our population.**
- **We maximise our impact for good and our population plays its part in living well.**

Developing our digital infrastructure | Building capacity and capability | Embedding the culture for success

Our People

NHS
Humber Health
Partnership

We can only deliver the scale of change that is needed if we have the right people, with the skills, knowledge and motivation to continually improve.

Delivering our strategic ambitions will require us to build the confidence and resilience of our people – instilling pride in our group and the work that we do.

We will:

- **We will look after the health and wellbeing of our people**
  - We will get the basics right for our teams, improving working environments, providing space for reflection and support to build resilience.
  - We will improve our approach to flexible working, to ensure we retain talent and enable our people to give their best at work and at home.
  - We will tackle discrimination head-on and ensure all our people are living out our values of compassion, honesty, teamwork and respect.
- **We will support our people to grow and develop to their full potential**
  - We will work to build a genuinely inclusive culture that celebrates diversity and promotes belonging so that everyone feels safe and can thrive.
  - We will make it easier for our workforce – including our volunteers – to move around between different organisations and sectors and find the role for them.
  - We will focus on talent development, supporting people to grow in their roles and work at the top of their professional licence.
- **We will build a flexible and adaptable workforce for the future**
  - We will work with our training partners to develop curricula that focus on core competencies, adaptability and innovation to help our future workforce to be creative and embrace change.
  - We will build the digital capabilities of our people to ensure they are fully equipped to deliver new ways of working for the future.
- **We will make a positive impact on our communities through our people**
  - We will re-double our efforts to inspire and support our workforce to make healthier choices for them and their families, causing a ripple effect of healthy changes across our communities.

Performance

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Partnership

To turn the dial on our performance as a group, we need to radically change what we do and how we do it.

We will transform everything that we do and how we do it with a focus on delivering slick processes, eliminating unnecessary bureaucracy, and putting care in its rightful place.

We will:

- **We will streamline processes and remove duplication**
  - We will have a laser focus on eliminating manual processes and workarounds.
  - We will invest to save by building the digital infrastructure that allows us to remove paper-based systems.
  - We will put in place clear governance processes with as few steps as possible to enable fast and effective decision-making and implementation of change.
- **We will eliminate unwarranted variation in our service delivery**
  - We will develop delivery plans for our 14 Care Groups that align models or care and ways of working across both banks of the Humber, adopting “best in class” from across our organisations.
- **We will do things once**
  - We will look at every service and function to identify where improvements and efficiencies could be made by consolidating activities, teams and functions and doing things once across the system.
  - We will review our physical estate and rationalise wherever possible – looking at our assets across the system, not just within our organisations.
- **We will develop sustainable models of care**
  - We will reorganise our services to make the best use of people, buildings and equipment, focusing on delivering quality local services as close to home as possible and highly specialised care from defined centres of excellence.
  - We will build robust digital foundations that are secure, resilient and work seamlessly across departments, organisations and sectors.
  - We will improve the way we use data to drive decision-making in real time and plan more effectively for the future.

Quality and Safety

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Partnership

Being kept safe and well looked after is one of the top priorities for the people who use our services. As demand for our services continues to grow, we need to think very differently about how services are organised to ensure we can continue to provide safe and good quality services for our local communities.

In all that we do, we will strive to provide the kind of care we would want for ourselves and our loved ones.

We will:

- **We will keep our patients safe and reduce avoidable harm**
  - We will embed a safety-focused culture, supported by systems and processes that enable teams to deliver reliable, high-quality care.
  - We will make it easy for patients, loved ones and staff to speak up if they see something that isn't quite right and build a positive culture of learning and improvement.
- **We will deliver the best outcomes for our patients**
  - We will strive to get the best possible outcomes for every patient, recognising that what defines a good outcome will be as individual as each person we treat.
  - We will empower teams to be responsive to patient needs, giving them space to innovate and try new things and adapt what they do to suit different needs.
  - We will improve the way our teams communicate with one another, with our patients and with other organisations to ensure they are all working together as effectively as possible.
- **We will work hard to provide a positive experience for our patients and their loved ones**
  - We will really listen to our patients and their loved ones and tailor our care and support to their needs and what matters to them.
  - We will build our services around our patients and their needs, adopting a home first approach radically rethinking how and where we provide care.
  - We will see carers, family members and loved ones as an asset and encourage them to get involved in their loved one's care.
- **We will equip our patients to live healthier lives**
  - We will use every conversation to provide our patients with the tools and the knowledge they need, and the encouragement of a trusted healthcare professional, to make small but impactful changes to their health and wellbeing.

Research and Innovation

NHS
Humber Health
Partnership

We are ambitious for our people and our population. We want to be at the leading edge of healthcare research and innovation.

Research and innovation can help us to find the new systems and ways of working we need to adapt to the changing demands of the future. We must re-focus our efforts to maximise the impact of research and innovation.

We will:

- **We will build the infrastructure we need to deliver excellent clinical research**
  - We will work with academic and industry partners to deliver the facilities, data and digital infrastructure we need to undertake quality, impactful research.
  - We will promote our nursing, midwife and allied health professionals to undertake research – giving appropriate time and resources to enable more professionals to be research-active.
  - We will build confidence and health literacy amongst our patients to enable them to make informed choices about participating in clinical trials and other research opportunities, making research more inclusive to improve our population's health.
- **We will align our research efforts to the big questions facing our population**
  - We will apply the advanced skills and knowledge of our scientific community to the big challenges facing our population and our workforce today.
  - We will work with leading research institutions who have the expertise and connections we need to find the solutions to our unique set of challenges.
  - We will leverage our industry partnerships and expertise in carbon reduction and sustainability to ensure we are leading research and helping to define the future of sustainable healthcare.
  - We will build our research capabilities and use our unique skills and assets to support wider economic regeneration in the Humber region.
- **We will equip our people to innovate and transform**
  - We will work with training providers to build research skills and capacity into curricula so that we can develop more homegrown researchers and our clinical and professional staff are engaged in relevant research that contributes to continuous improvement of our services.
  - We will foster creativity and entrepreneurship by giving greater autonomy to teams to deliver objectives within a framework.
  - We will engage and involve our communities in research and innovation, giving them a voice and influence over shaping the solutions.

Partnerships

NHS
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Partnership

We cannot achieve success without the support of our partners, our people and our communities.

To deliver our strategic ambitions, we must solidify our existing partnerships and leverage the influence we have as a group to forge new relationships with people and organisations within and beyond the Humber.

We will:

- **We will play a vital role in local health and care partnerships**
  - We will work with partners in each of our local areas, recognising the unique challenges and opportunities in each geography, taking time to build strong relationships with each place.
  - We will build trust and credibility with our partners so that together we can take risks to deliver the type of radical change we need.
  - We will support our teams to develop closer relationships with partners at an operational level, encouraging joint ownership and collaborative problem-solving.
- **We will use our size and scale to bring national and international attention to the Humber region**
  - We will leverage the influence we have as a group to forge new relationships with wider academic and industry partners, to advocate for our region and its people and attract investment and increased attention into our area.
  - We will forge new partnerships with industry – both local and further afield – to deliver our ambitious net-zero targets and play our role in driving economic regeneration on and around the Humber estuary.
  - We will forge closer links with other like-minded organisations and influential institutions in the North, so that together we can have a stronger voice to advocate for our populations. Working together we will amplify our voice and ability to influence national policy.
- **We will define a new relationship with our communities**
  - We will take time to listen to our communities and to really understand their needs, wants and aspirations.
  - We will be clear with our population about what we need from them – and what they can do to support their own health and wellbeing.

Foundations for success

Delivering these actions will only be possible if we also put in place the building blocks we need – digital infrastructure, leadership capacity and capability and a culture for success.

Humber Health Partnership

Digital

- **We will transform our approach to digital, data and technology to enable comprehensive change**
  - We will build robust digital foundations that are secure, resilient and interoperable.
  - We will improve the way we use data to drive decision-making in real time and plan more effectively for the future.
  - We will build a virtual hospital, which will work alongside our physical sites and be fully integrated into our existing service offer.
  - We will keep digital inclusion at the heart of what we do so that those living in our most deprived communities are not excluded.

Leadership

- **We will build capacity and capability at every level, growing the leaders we need for today and tomorrow**
  - We will develop leadership capacity and capability at all levels, giving our people the tools and permission they need to lead change in their area.
  - We will nurture local talent and develop the dynamic, flexible workforce we need for the future.
  - We will build on our record of widening participation, youth volunteering and apprenticeship schemes, to grow our own future workforce – going out of our way to offer tailored opportunities that will inspire and enable local people to enter rewarding careers in health and care.

Culture

- **We will build an inclusive, just and learning culture that encourages creativity and collaboration**
  - We will work to build a genuinely inclusive culture where diversity is celebrated, and the unique skills and perspectives of each individual are recognised and rewarded.
  - We will build a culture of continuous improvement where all staff feel empowered to lead change.
  - We will embed a culture that rewards creativity, encourages appropriate risk-taking and supports people to learn from failure.
  - We will develop a culture that is outward-looking and willing to embrace new perspectives and ways of doing things.

What does it mean for me…?

Humber Health Partnership

Over the next five years, **we will challenge everything we do and how we do it**.

We will completely redesign pathways and services so that they work for the people who use them rather than fitting around the needs of those who provide them.

This means that, in the future, people will come to hospital less often and stay for less time. People living with long-term conditions will be supported and encouraged to manage their conditions at home and have a clear route for escalation when they need more help or medical input. We will work much more closely with GPs, primary care, mental health, community services and voluntary and community sector organisations so that people do not feel passed from pillar to post but instead can see everyone is working together and joining things up.

What this means for Jean

Jean is 86 years old and lives in a flat in Cleethorpes. She has several health conditions including Atrial Fibrillation and arthritis. Last year she had an operation after she fell and broke her hip.

A traditional approach

Jean has lots of different appointments with hospital doctors in different departments, for each of her conditions. These happen on different days, and sometimes she forgets to tell the doctor about recent changes in her health.

When her condition gets worse, she gets unsteady on her feet and recently she has had several falls.

Over the last few years, Jean has had multiple admissions to hospital and the last time she stayed for several weeks because she needed some extra support to get around at home.

How things could look different

Jean wears an electronic monitoring device that is connected to a control centre. When Jean's condition worsens, the device triggers an alert and automatically creates an appointment for a specialist nurse to call Jean and see how she is doing and put in place changes that could prevent a future fall.

Jean's multi-disciplinary team meets together and can share notes about her care when they need to.

When Jean does get really unwell and need hospital-level care, this can be provided through the virtual hospital in her own home.

Building the Virtual Hospital

Over the next five years, we will build a virtual hospital. Our virtual hospital will work alongside our physical sites and be fully integrated into our existing service offer.

This will enable us to build on the pockets of good practice we have already – such as our COPD virtual ward or paediatric Hospital at Home – and expand our offer into homes, including care homes, across the region.

Virtual care, virtual wards and remote monitoring at scale will drive improved efficiency of services, reduce footfall on our hospital sites and support people to have a better experience of care.

We will keep digital inclusion at the heart of what we do so that those living in our most deprived communities are not excluded.

How will we know if we are successful?

NHS
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Partnership

As we continue our journey to excellence, we will measure our progress against a range of factors to see if we are on track to achieve our target outcomes.

Our people feel proud to work here

Our people feel proud to work here and they have the skills, knowledge and permission to lead change.

- Staff survey (*%age would recommend as a place to work and a place to be treated improved*)
- Recruitment and Retention (*vacancy rates reduced, turnover reduced*)

Our patients get the best care

We are the best at what we do, and we only do the things that we are best placed to do.

- Upper quartile performance in all services
- Positive report from regulators (*CQC ratings are improved*)
- People only come to hospital when they absolute need to and don't stay any longer than is necessary (*NCTRs reduced, follow-up OP rates reduced, LoS reduced, ED activity shift to UCS/UTC*)

Local people live more years in good health

We maximise our impact for good – inspiring and equipping our population to live well.

- Maximise our role in secondary prevention (*referral/success rates e.g., tobacco dependency*)
- Improve health and wellbeing of our staff (*self-reported wellness ratings?, staff sickness*)
- Improving healthy life years (*HLE improvements, esp. for women*)

We are recognised as leaders in our field

We are recognised as leaders in our field, and we use our privilege to advocate for better health for our population.

- Leader in rural and coastal health research (*research impact score/number of research studies and partnerships*)
- Leader in sustainable healthcare and NetZero (*carbon reduction achievement/income generation*)
- Providing specialist and tertiary services across a wider region (*activity levels/income generation*)

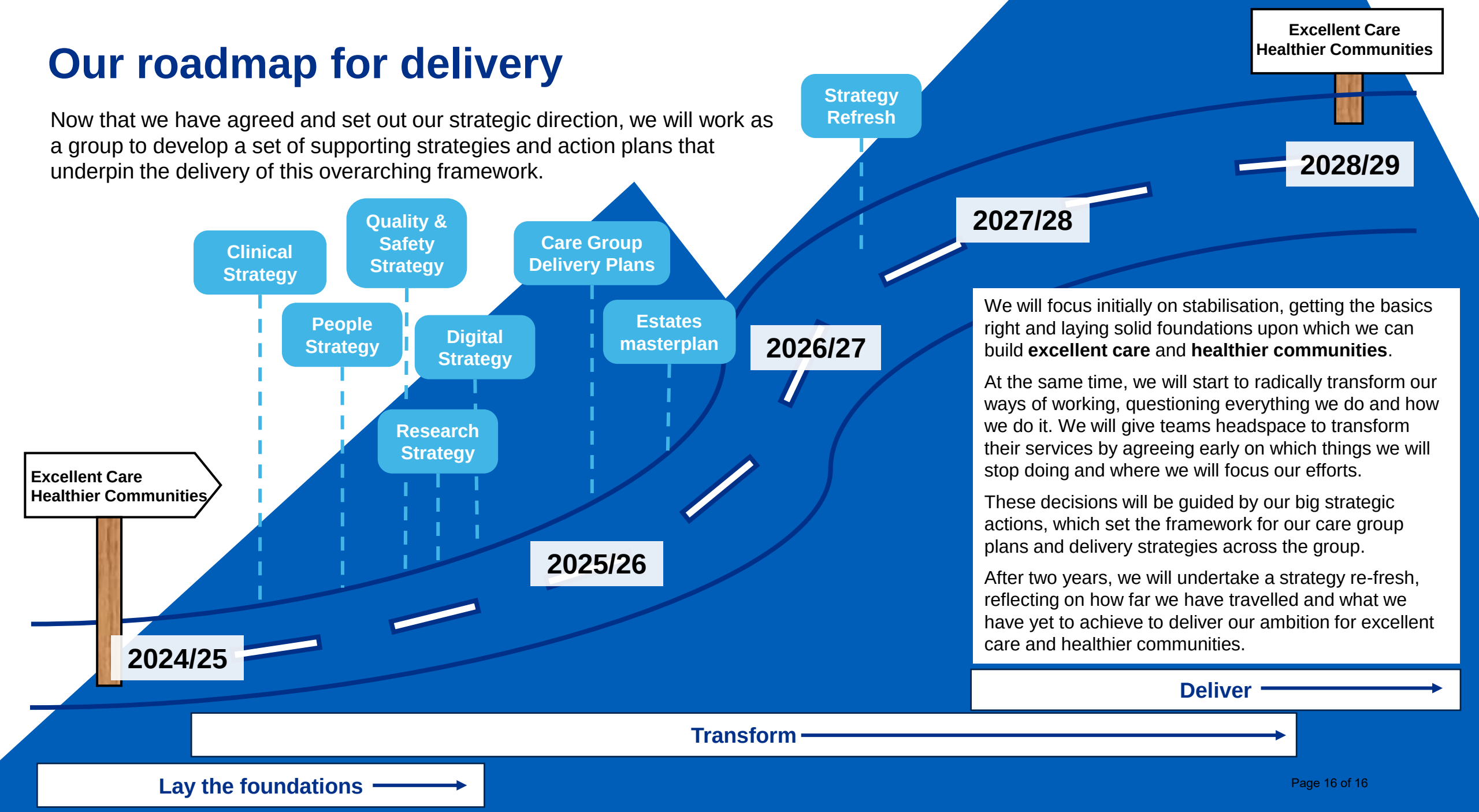
Our communities feel proud of what we offer

Those facing the biggest barriers are given the most support and it is provided in a way they can easily access.

- People have a good experience of care (*FFT, PALS/complaints*)
- People can easily access the care they need (*Support for travel, digital inclusion*)
- Population health need drives service access (*PTL by equality characteristics – reduced inequalities*)

Our roadmap for delivery

Now that we have agreed and set out our strategic direction, we will work as a group to develop a set of supporting strategies and action plans that underpin the delivery of this overarching framework.



We will focus initially on stabilisation, getting the basics right and laying solid foundations upon which we can build **excellent care** and **healthier communities**.

At the same time, we will start to radically transform our ways of working, questioning everything we do and how we do it. We will give teams headspace to transform their services by agreeing early on which things we will stop doing and where we will focus our efforts.

These decisions will be guided by our big strategic actions, which set the framework for our care group plans and delivery strategies across the group.

After two years, we will undertake a strategy re-fresh, reflecting on how far we have travelled and what we have yet to achieve to deliver our ambition for excellent care and healthier communities.

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)154

Name of Meeting	Trust Boards in Common
Date of the Meeting	8 August 2024
Director Lead	Simon Nearney, Group Chief People Officer
Contact Officer / Author	Myles Howell, Group Director of Communications
Title of Report	Group Staff Charter development and deployment
Executive Summary	Between December 2023 and March 2024 group staff were given the opportunity to share their views on a set of values for our organisation. At a series of focus groups held during March the shortlist of values from the engagement sessions was consolidated to four, subsequently agreed at cabinet and board: Compassion, Honesty, Respect and Teamwork. The final phase of this piece of work was to develop a series of values-aligned behaviours – a staff charter – that described how we expect everyone in our group to show up at work at all times. The charter is essential for nurturing a respectful, cohesive, and high-performing organisational culture. The boards are asked to discuss and approve the staff charter and deployment plan.
Background Information and/or Supporting Document(s) (if applicable)	Appendix 1 – Staff Charter
Prior Approval Process	WECC, JNCC, Trust Board Development
Financial Implication(s) (if applicable)	**N/A**
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	The charter provides a behavioural foundation for all staff to understand their responsibilities in respecting and understanding the diversity of views and preferences across our workforce and our patient and public populations.
Recommended action(s) required	✓ Approval ☐ Information ✓ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

NHS HUMBER HEALTH PARTNERSHIP

GROUP STAFF CHARTER

1. Purpose
   The purpose of this paper is to request that the Trust boards in common discuss and approve a group staff charter, which sets out behavioural expectations of all staff working at NHS Humber Health Partnership, in line with the agreed values: Compassion, Honesty, Respect and Teamwork.

2. Background
   Between December 2023 and March 2024 group staff were given the opportunity to share their views on a set of values for our organisation. Over 3,000 staff attended face-to-face workshops, virtual workshops and or completed an online values survey offering their preference for our group values. At a series of focus groups held during March the shortlist of values from the engagement sessions was consolidated to four, subsequently agreed at cabinet and board: Compassion, Honesty, Respect and Teamwork.

   The final phase of this piece of work was to develop a series of values-aligned behaviours – a staff charter – that described how we expect everyone in our group to show up at work at all times.

3. Rationale for a staff charter
   Our staff behaviours charter sets out expected conduct within our group. Its primary purpose is to establish a clear and consistent standard for workforce behaviour, fostering a safe, compassionate, caring, positive, respectful, and productive work environment. The staff charter will help to prevent misunderstandings and conflicts, promoting a harmonious workplace culture.

   The charter supports the group's core values, developed in conversation with staff, ensuring that all employees are aligned to a common set of agreed ethical standards. It acts as a guide for decision-making and interactions, encouraging professionalism, integrity, and accountability. This uniformity in behaviour, which must be led by the boards in common and role-modelled at the same level, is crucial for maintaining trust and collaboration among employees, which in turn enhances engagement, efficiency and effectiveness.

   Additionally, a staff behaviours charter aids in conflict resolution by providing a reference point for addressing issues related to conduct. It empowers managers and HR personnel to manage disciplinary actions fairly and consistently, based on predefined criteria.

   Moreover, the charter can serve as a vital tool during induction, onboarding and training, helping new starters as well as existing staff to understand the organisation's expectations and integrate seamlessly into their teams.

   Ultimately, our staff behaviours charter is essential for nurturing a respectful, cohesive, and high-performing organisational culture.

4. Deployment
   The Group Staff Charter must be read and understood by everyone working in our organisation. Furthermore, it must be a living document, its contents discussed at every opportunity, and the behaviours within role-modelled at all levels in the group; most of all at board level.

Across the group there are multiple channels presenting us with the opportunity to communicate and deploy the staff charter, some will be used to launch the charter others to offer the opportunity for the charter to be discussed and utilised:

CHANNEL	METHOD	FREQUENCY	LEAD
All internal communications (Bridget, Weekly, CEO Bulletin, Ask the Chief Executive, Core Brief etc)	Generic sharing of charter for all staff with link to intranet version	Launch	Group Director of Communications
Group corporate induction	Full description and explanation for all new starters	Monthly	Group Director of Learning and OD
Local induction	Manager/new starter discussion to set expectations at service level	As required	All line managers
Appraisal	Line manager/employee discussion in every appraisal regarding adherence to charter	Annual	All line managers
Training programmes – standard item (ie, incorporated into housekeeping)	All learning sessions to be conducted in accordance with the staff charter	As required	Training session facilitator
All board, and board level meetings – standard agenda item	Review adherence to charter at the end of all meetings	Every meeting	Committee chair
All formal (minuted) meetings – standard agenda item	Review adherence to charter at the end of all meetings	Every meeting	Meeting chair
Freedom to Speak Up Guardians	Share and discuss with all staff raising a behavioural concern	As required	FTSUGs HUTH and NLaG
HR/staff side representatives	For use in formal behavioural investigations	As required	HR advisors
Shining Lights – monthly award	Reward and recognise staff who are demonstrably showing compliance with the charter	Monthly	Group Chief Executive
Golden Stars – Group Chief Executive's Award	Reward and recognise staff who are demonstrably showing compliance with the charter	Annual	Group Chief Executive
Very Senior Managers Execs,	Create a personal assessment and 360	Annual Appraisal	Group Director of Learning and OD

NEDs and Directors	feedback tool to ensure that all VSM's are role modelling the values and staff charter behaviours		
Line Manager Training – how to set your team values and staff charter	Roll out to all line managers training on how to use values to share staff charter and create team charter. Track engagement and map to staff survey results and other key people metrics.	One off training for managers	Group Director of Learning and OD
Challenged Teams identified by staff survey league table	Use data to identify poor staff engagement scores resulting in poor behaviours and performance and target these teams with Values and Staff charter sessions.	One off sessions with follow up OD support if required	Group Director of Learning and OD
Cultural Ambassador Scheme	Build upon existing "champion roles" in HUTH and NLAG to promote the values and staff charter to their team.	Monthly meetings and support	Group Director of Learning and OD
People Managers Mandatory Training	All line managers required to complete a module ensuring they are clear that they have to role model values/staff charter and ensure they know how to deal with challenging behaviours within their teams.	Launch and then repeat every 3 years	Group Director of Learning and OD

5. Recommendations
   The Boards in Common are asked to discuss the Group Staff Charter, agree its contents and ongoing plan for deployment, in order that the Charter can be launched with immediate effect.

Staff charter

NHS
Humber Health Partnership

COMPASSION

Put the safety and care of patients and colleagues at the heart of everything you do

Listen to your colleagues and patients, understand, empathise and take action to help

Treat everyone with kindness and support those who need assistance or guidance

Do the right thing, even if this is more difficult to do

HONESTY

Take responsibility for your actions, decisions and behaviours

Report concerns about safety, quality and negative behaviours as quickly as possible

Communicate constantly and clearly at all times; create and respond to a constant loop of honest feedback

Be open about mistakes, apologise, learn and improve

RESPECT

Trust and appreciate your colleagues - say thank you and well done

Talk to everyone in a respectful and polite manner and listen when others want to speak

Understand and appreciate the perspectives, choices and beliefs of others and never discriminate against anyone

Respect and use each others' strengths; act respectfully by giving, receiving and acting on constructive feedback

TEAMWORK

Meet regularly as a whole team, discuss goals, actions and ideas for improvement. Commit to being good team members

Include all colleagues in key discussions about the team or service

Tackle poor behaviours as they arise

Agree high professional standards as a team; give yourselves time to reflect on how to constantly improve

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)155

Name of Meeting	Trust Boards-in-Common (Public)
Date of the Meeting	Thursday 8 August 2024
Director Lead	Sue Liburd, Committee Chair of Quality and Safety CIC and David Sulch, Committee Chair of Quality and Safety CIC
Contact Officer / Author	Sue Liburd, Committee Chair of Quality and Safety CIC and David Sulch, Committee Chair of Quality and Safety CIC
Title of Report	Quality and Safety Committees in Common Minutes – May and June 2024
Executive Summary	The Quality and Safety Committees in Common minutes from meetings held on 23/05/24 and 30/06/24
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Quality and Safety Committees in Common held on 30/06/24 and 31/07/24
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

QUALITY & SAFETY COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Thursday 23 May 2024, 9.00 - 12.30 in the Boardroom, Hull Royal Infirmary

For the purpose of transacting the business set out below:

Present:

Core Members:

Sue Liburd	Non-Executive Director NLAG
David Sulch	Non-Executive Director HUTH (chair)
Kate Truscott	Non-Executive Director NLAG
Amanda Stanford	Group Chief Nurse

In Attendance:

Jo Ledger	Deputy Chief Nurse HUTH
David Sharif	Group Director of Assurance
Neil Rogers	Managing Director (North)
Pete Sedman	Group Deputy Chief Medical Officer
Rob Chidlow	Interim Group Director of Quality Governance
Richard Dickinson	Associate Director of Quality Governance NLAG
Rebecca Thompson	Deputy Director of Assurance
Michela Littlewood	Associate Director of Quality HUTH
Rukeya Miah	Head of Midwifery HUTH
Lesley Heelbeck	National Maternity Improvement Advisor (NHSE)
Kevin Allen	Public Governor (observer) virtual
Nicola Buckle	Senior Matron, IPC (item 4.4)
Rachel Wright	PA to Group Chief Nurse (notes)

KEY

HUTH – Hull University Teaching Hospitals NHS Trust
NLAG – Northern Lincolnshire & Goole NHS Foundation Trust

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The Committee chair welcomed those present to the meeting. Apologies were noted from Kate Wood (Pete Sedman rep), Shaun Stacey (Neil Rogers rep), Jennifer Granger (Richard Dickinson rep), Nicky Foster, Melanie Sharp.

1.2 Declarations of Interest

No declarations of interests were received in respect of any of the agenda items.

1.3 To approve the minutes of the meeting held on 24 April 2024

The minutes of the meeting were accepted as a true and accurate record.

1.4 Matters Arising

The Committee chair invited committee members to raise any matters requiring discussion not captured on the agenda. None were raised.

1.5 Committees-in-Common Action Tracker

The action tracker was updated prior to the meeting. The Committee approved the updates to the action tracker.

1.6 Operational pressures update

Jo Ledger updated the Committee regarding her recent on-call and commended both North and South Bank teams for their co-operation and team working.

2. MATTERS REFERRED

2.1 Matters referred by the Trust Board(s) or other Board Committees

The committee chair reported there were no matters referred.

3. RISK & ASSURANCE

3.1 Board Assurance Framework (BAF)

Rebecca Thompson presented the Q4 risk ratings and asked the Committee to ratify the ratings and recommend approval by the Boards in Common in June 2024.

The Committee approved the sign off of the Q4 BAF risk ratings.

3.2 Risk Register Report

Amanda Stanford explained that the proposal was to undertake a cleanse and review exercise with the care groups/triumvirates to identify all risks and separate out all of the issues. Once completed this would be presented to the Committee in September/October 2024.

Neil Rogers raised an ask from the Care Groups that they hope to eventually work from one Risk Register. Rob Chidlow explained how there was work going on behind the scenes to create a new single Group system.

4. COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 Integrated Performance Report (IPR): quality & safety metrics

Rob Chidlow explained the data presented was the top 10/11 metrics from both HUTH and NLAG performance systems as part of the Group transition.

David Sulch asked for an update on the national patient safety alert for bed rails. Richard Dickinson said up to 65% of actions had been completed but there were still challenges around the implementation of policy and process. There had been an issue in NLaG within community services and had been provided with a Community Equipment Provision Service. This requires staff to go out and assess patients they have issued to in the past. A plan was in place and work was ongoing with support from the ICB. Good progress had been made on the other actions. Rob Childlow explained the alert affected both Trusts but an integrated approach was being taken.

David raised the question of the SHMI at NLaG and why the control intervals had decreased on the SPC charts to 7 data points and was this a trend. Richard Dickinson explained that there was not a specific reason, but agreed to review the data and what was causing the downward trend.

Kate Truscott raised concerns regarding Information Services and asked if they were able to help. Rob Chidlow advised that the reports were still work in progress and the data was still being manually lifted from source. Kate Truscott suggested that data quality and how information was shared with the Care Groups was a risk.

Kate Truscott brought attention to a particular ward in relation to pressure ulcers and how the Trust (NLAG) and the Group was addressing this issue. Amanda Stanford explained a lot of work had been done on this over the last year and that there was a correlation between falls and pressure ulcers. When the number of falls went down, pressure ulcers would go up. Amanda advised that she would work with the Patient Safety team to manage the risks. Richard Dickinson added that assessments within the first seven days was key and that there was a strategic plan in place being monitored through regular meetings relating to patient care on the wards.

4.2 CQC Improvement Plan

4.2.1 HUTH CQC Improvement Plan

Amanda Stanford explained there had been a reset of maternity governance and delivery groups were now established for MIS year 6, the 3-year improvement plan and CQC actions. The CQC meeting to be chaired by Jenny Hinchliffe and would report into Maternity Transformation Assurance Committee. This would help to identify risks and what issues need oversight. Discussions have been had around ‘Must Do’s’ on the CQC action plan and how we deliver these in the new structure. A piece of work was to be planned to review progress to date highlighting any Care Group risks to the Committee.

David Sulch enquired if the CQC actions had been shared across Care Groups. Amanda Stanford explained that they would and work was ongoing to ensure there was no duplication of effort. Good practice would be shared across the sites and actions refreshed in line with the CQC requirements.

4.2.2 HUTH Maternity CQC Improvement Plan and S31 Update

David Sulch asked the question around the maternity report for HUTH. Eleven actions were rated as 'off track' although the target delivery dates were highlighted as April 2024. An update of the outstanding actions would be carried out at the MTAC meeting. Rukeya Miah advised that it was only the difficult to do actions that were outstanding.

4.2.3 NLAG CQC Improvement Plan

Amanda Stanford advised there would be an informal visit from the CQC on 24 May to walk round the Emergency Department at Grimsby Hospital.

4.3 CQC Statement of Purpose: Annual Review

The Statement of Purpose was presented and Amanda Stanford had no concerns to raise. It was agreed this item would not be presented to the Committee in future unless any specific changes were made.

There was a discussion around the statement reflecting the Trust's current state and whether the compliance systems and processes were robust. The Committee was assured and confident of the processes in place and that any changes would be highlighted.

4.4 Infection, Prevention & Control Quarterly BAF

Nicola Buckle gave the background to the IPC BAF. NLaG do not currently have an IPC BAF but the aim is to align the process at both Trusts. The HUTH BAF reports through the Strategic Infection Reduction Committee for monitoring purposes before being presented to the Committee.

Improvements had been seen in Pharmacy, within Nervecentre by identifying patients at risk and AMS guidance. The team are working on the education and training which had improved and the face fit testing team was reinstated in November following submission of a business case. Feedback had been positive regarding FFT, and the team consisted of 3 staff members who were working through the backlog.

Jo Ledger expressed how the implementation of BAF had been helpful as a framework and that it had been very positive driving improvements and positive working relationships with the teams.

David Sulch asked about the plan for the NLAG IPC BAF and Amanda Stanford advised that the aim was to standardise the approach and have one IPC Team that would report to the Group Chief Nurse.

Kate Truscott asked about microbiologist support and Nicola confirmed there was good support at HUTH.

David Sulch expressed how quarterly reports would be very helpful highlighting key concerns, actions and timelines to address the actions.

The Committee was assured that the appropriate process was in place alongside the correct monitoring.

4.5 Nursing Assurance Report (including ward accreditation & fundamental standards, safe staffing)

Jo Ledger updated the CIC on the HUTH Nursing Assurance Report. There was an increase in April to 7.74 CHPPD. Ward one was still open and offering extra capacity. Medicine was running at 100% occupancy, and the Elective wards around 95%. A reduction in patient numbers was seen in April, but that was noted to be because of the Bank Holidays. HUTH currently had 67 registered Nurses which equates to 2.55% of the budget establishment for Nurses and Midwives. There were vacancies open for Non-Registered Nurses. HUTH is over established currently but turnover had slightly increased at 7.1% but was still less than the previous month at 10.2%.

Jo updated the Committee on the current falls across the organisation and HUTH was starting to see a significant reduction. Last month, patients that fell with moderate harm had reduced and a weekly meeting was in place for all Band 7 Nurses to attend to present any falls and any learning.

Amanda Stanford updated on the staffing element at NLaG and expressed it was not too dissimilar to HUTH, but she was working with Jo Ledger comparing establishments. She also expressed that there was work to do on the South Bank around hand hygiene which showed on the Quality Metrics for the IPC.

Amanda Stanford informed the Committee that SNCT was being rolled out across the community to capture learning.

Sue Liburd asked a question around Pressure Ulcers at NLaG and if there is any correlation between the areas who report high numbers of pressure ulcers and tissue viability training. Amanda Stanford stated that this was something that the Tissue Viability Team were reviewing.

The Committees in Common were assured that the monitoring and learning processes were in place.

4.6 Maternity & Neonatal Assurance Report (including Ockenden, CNST MIS, incidents/MNSI)

HUTH Maternity & Neonatal Assurance Report
Rukeya Miah updated the Committee and advised that the new Director of Midwifery had not yet commenced with the Group but was due to join on 10 June.

Rukeya Miah updated that the mortality data that the Trust had was 15% lower than the national average of neonatal deaths.

There was a piece of work ongoing relating to the antenatal use of steroids in the first seven days of pregnancy. This was a collaborative piece of work with the obstetricians, midwifes and the QI Lead. Rukeya raised a concern relating to Intrapartum Antibiotics with the national standard being100% and the Trust was showing 14%.

Positive feedback was given as to how well the Trust performs on receiving breast milk on the day of birth, which sits at 89%. The national average was 50%. Rukeya

Miah also shared success in the Admission for Temperature of 36.5 to 36.7 range, at 93%.

There had been a suggestion from the QI Lead to have an obstetric and a Neonatal focused Team that were just collaborating on key areas as this would have the biggest impact on saving babies life's and mortality.

Lesley Heelbeck joined the meeting at 10.23am.

NLAG Maternity & Neonatal Assurance Report
Amanda Stanford updated the Committees in Common that recruitment still remained a challenge for Midwives. There was a discussion around interim posts for specialist midwives and how these could be made substantive. Short term funding bids from Ockenden were being developed.

Lesley Heelbeck offered her support to HUTH and NLaG and informed the Committee she was waiting to get stakeholders together which would help with recommendations and advice to support the Group.

Sue Liburd updated that the NLAG Maternity Transformation Meeting has been stood down, and that maternity assurance would be moved to a Board in Common. Sue emphasized the importance of sovereign organisation reporting and not becoming complacent with NLAG when considering it alongside HUTH maternity services improvement requirements.

The Committees in Common were assured that maternity services were being managed appropriately and the correct monitoring was in place.

4.7 PSIRF/Serious Incidents (including Duty of Candour and lessons learned)
The report was presented for information and highlighted LFPSE commitments from the Group.

Further amendments were being made to the report to align it across both Trusts.

4.8 CLIP Report (including triangulation of incidents, complaints/PALS and claims & lessons learned)
Richard Dickinson updated the Committee and advised that work was ongoing to align the Trust's reporting. Richard advised that Legal Services was now a Group team and a review of coding would be required to present a uniform approach.

In NLaG the inquest numbers were discussed and it showed that fewer inquests were being held compared to those being opened.

Patient Experience data showed that delays were the top theme. Staff feeling pressured had also impacted on patient feedback. Feedback was gathered by paper on the South Bank whereas the North Bank had a text message service. The rate of negative comments in the feedback was falling.

Rob Chidlow updated that on both patient experience teams in the North and South they have been faced with capacity issues due to sickness.

David Sulch asked about data relating to harms caused by delayed discharges and Richard Dickinson advised that it was not collected but this could be checked as part of the coding review.

The CIC discussed the report as working progress, Sue Liburd stated that the report worked well for her, but expressed concern regarding losing key components when merging patient safety and complaints data.

The Committee were assured of the processes in place and the direction of travel.

4.9 Quality Impact Assessment (QIA)

Amanda Stanford updated the CIC regarding Quality Impact Assessments and changes have been made to Policy which was being taken through the Finance Improvement Board for approval. The content within the Policy was a revised approach and is now an Equality and Quality Impact Assessment rather than Quality Impact Assessment. The assessment tool has been created from external organisations for a fresh approach.

The aim was for the Care Groups to meet weekly to review CIP Plans and anything requiring an Equality and Quality Impact Assessment before being approved at Site and then Executive level.

The Committee was assured with the new process and David Sulch commended the team on adding Equality within the assessment.

4.10 Register of External Agency Visits

A verbal update was given to the Committee; Rob Chidlow advised the visit of the BNA Screening from NHSE had gone well. Feedback around the clinical model was that it was well led and had good governance procedures in place.

Capacity and demand issues raised at the AAA screening visit had resulted in discussions around funding. The services were yet to receive the final report from the visit.

A report was received relating to the HTA visit in March and there was a working group in place managing the actions. David Sharif advised that were also a series of suggestions raised to help improve security at the mortuary.

4.11 Mortality including Learning from Deaths

Pete Sedman explained that the two organisations had been on different paths over the last six years and that the South Bank numbers had come down from ‘Higher than expected’ to ‘as expected’ and had stayed there for the last 4-5 years. The North Bank is currently in ‘higher than expected’ after some fluctuation with ‘as expected’. By joining the two systems across the North and South the data over the last 4 months was being reported as ‘higher than expected’.

Referring to HUTH, Pete Sedman explained the data had been broken down between sites and showed that most of the change had occurred at Castle Hill Hospital and the specialties that are there. The first specialty that was discussed was Oncology, and this showed a higher rise at Castle Hill Hopsital which is believed to be from a change in practice in that all Oncology Patients

now being seen in the Day Case Unit at Castle Hill Hospital where they are now coded as a ‘day care’ rather than an admission. This shows that the number of deaths has not changed dramatically in this group of patients. Pete Sedman also explained that there was a concern around patients not being coded for palliation at an early stage of a patients management, which leads to patients not receiving active treatment. Work was ongoing to introduce RESPECT forms at an earlier stage.

Pete Sedman explained that Cardiology in HUTH had seen a rise in deaths from acute myocardial infarction over the last 2 years. This was the second biggest group. Analysis showed that there was a significant rise in the number of patients coming from out of the area and it was thought to be connected to the timing of transport or the nature of transfer of MI patients.

Fractured neck of femur was raised as a concern, and data showed there had been an additional 20 deaths at HUTH in the last year. It was explained how these deaths were likely to be multifactorial and not necessarily the only cause of the actual death. This could have been linked to a delayed discharge, or a possible issue of not getting patients into theatre in time. The orthopedic wards showed no change but had seen an increased demand in patients who have not been treated on the main orthopedic ward which could be linked to capacity.

Pete Sedman advised of another issue related to the acute trauma unit in HUTH. The areas of concern related to patients who appear in the TARN database but have not been treated as a Major Trauma, an example of this was rib fractures in elderly patients. As a result the rib fracture pathway had been changed along with an improved rib analgesia system.

Task and finish groups have been established to review how Sepsis patients are managed. It was discussed that a lot of great work had taken place in the last 3 years to help with early recognition of Sepsis, create and updated pathway and monitor patients on Nervecentre the digital system. Pete Sedman did state that more work was required in this area, including aligning the Sepsis pathways across the Group and incorporating paediatrics.
Rob Chidlow gave credit to work that was ongoing and the clear reporting across the Group.

Kate Truscott asked the question in regards to the Mechanical Thrombectomy during the working week of 30% and what happens to the other 70%. Pete Sedman explained that this was a national piece of work, and NHSE was working to expand the service to be 24/7.

David Sulch asked about the new Group pathways and how services were being organised across the North and South banks. Peter Sedman explained that some patients from Scunthorpe would be treated at Castle Hill now depending on capacity and appropriateness. David Sulch asked how this impacted on both hospitals mortality figures and Pete Sedman advised that there was more work to do.

The Committee agreed that processes were in place, but more needs to be done. Limited assurance was given.

4.12 Clinical Effectiveness Report (including clinical audit, NICE compliance, GIRFT, PROMS etc)

Rob Chidlow gave a summary and explained how both Trusts had work to do relating to Dementia compliance but that there was now a common process in place to manage this across the Group.

Rob Chidlow updated there was positive news regarding the SNAPP data for stroke and that both Trusts had moved forward. The Internal Audit draft report had concluded with only one recommendation, but there was still more work to do.

Rob explained how the NICE Guidance wasn't being reported at the Committees in Common level but was being reviewed in some of the sub-committees. At the time of the report, guidance compliance had improved from 65% to 73% and this would improve again when the team changes had been completed and there was Group process alignment in place.

The Committee agreed that processes were in place, and recognised the further work that was required. The Committee agreed limited assurance for this item.

4.13 CQUINs

The CQUIN report was presented by Richard Dickinson who highlighted the Flu vaccination rate as being particularly challenged.

Michela Littlewood advised that she was in communication with the ICB regarding the plans for the specialised commissioning areas. The Committee in Common was assured by the process and progress of the CQUINs.

NLAG Specific Business Items

There were no specific business items discussed.

HUTH Specific Business Items

There were no specific business items discussed.

5. STRATEGY

5.1 Mental Health Strategy Update

Kay Fillingham presented the NLAG Mental Health Strategy update. Sue Liburd asked how the Trusts made mental health awareness business as usual. Kay Fillingham explained that adding it to workplans, discussing holistic care, working with partners and promoting awareness were just some of the ways in which the teams were making sure it was known. Kay Fillingham updated that Scunthorpe Hospital had hosted a sponsored walk in aid of mental health awareness, where both Staff and Patients joined in. Sue Liburd thanked Kay for arranging the Scunthorpe sponsored walk and expressed it was well received.

6. ITEMS FOR INFORMATION/TO NOTE

- None

7. ANY OTHER URGENT BUSINESS

There was no other urgent business discussed.

8. MATTERS TO BE REFERRED BY THE COMMITTEES

8.1 Matters to be Referred to other Board Committees

- There were no matters referred

8.2 Matters for Escalation to the Trust Boards

It was agreed that the following matters required escalation to the Trust Board(s) in the committees' highlight report:

a) The Deputy Chief Nurse commended HUTH and NLAG staff on their joint working arrangements following a particularly difficult on-call session.

b) The new Care Groups are to review their CQC actions and highlight any risks to the services. The Committees in Common would continue to receive the progress updates.

c) **HUTH** IPC BAF would be presented as a quarterly report to the Committees in Common and annually to the Board. Key concerns, actions to address and timescales to be highlighted in the quarterly report. This process would be replicated at NLAG. The Committees in Common were assured by this approach.

d) After further review it was reported that the **HUTH** CQUIN relating to nutrition was now on track to achieve the target for full achievement.

9. DATE AND TIME OF THE NEXT MEETING

9.1 Date and Time of the next Quality and Safety CiC meeting:

Thursday 27 June 2024, 09.00 – 12.30 in the Boardroom, Hull Royal Infirmary

Cumulative Record of Attendance 2024

			Jan	Feb	Mar	Apr	May
Core Members							
Una Macleod	UM	Non-Executive Director (HUTH)					
Sue Liburd	SL	Non-Executive Director (NLAG)					
David Sulch	DS	Non-Executive Director (HUTH)					
Ashok Pathak	AP	Associate Non-Executive Director (HUTH)					DNA
Kate Truscott	KT	Non-Executive Director (NLAG)					
Tony Curry	TC	Non-Executive Director (HUTH)					DNA
Kate Wood	KW	Group Chief Medical Officer	CH				PS
Shaun Stacey	SS	Group Chief Delivery Officer	AA				NR
Amanda Stanford	AS	Group Chief Nurse Officer	MS		MS		

Attended	Apologies/Deputy sent	DNA

QUALITY & SAFETY COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Thursday 27 June 2024, 9.00 - 12.30 in the Boardroom, Hull Royal Infirmary

For the purpose of transacting the business set out below:

Present:

Core Members:

Sue Liburd	Non-Executive Director NLAG
David Sulch	Non-Executive Director HUTH (chair)
Kate Truscott	Non-Executive Director NLAG
Amanda Stanford	Group Chief Nurse
Kate Wood	Group Chief Medical Officer
Tony Curry	Non-Executive Director HUTH

In Attendance:

Stuart Hall	Vice-Chairman HUTH
Ashok Pathak	Associate Non-Executive Director HUTH
Jonathan Lofthouse	Group Chief Executive Officer
Jo Ledger	Deputy Chief Nurse HUTH
David Sharif	Group Director of Assurance
Richard Dickinson	Associate Director of Quality Governance NLAG
Rebecca Thompson	Deputy Director of Assurance
Michela Littlewood	Associate Director of Quality HUTH
Debbie Bray	Nurse Director, Family Services (item 4.6 only) virtual
Corrin Manaley	Public Governor (observer) virtual
Joanne Goode	Chief Pharmacist (HUTH)
Simon Priestley	Chief Pharmacist (NLAG)
James Illingworth	Research, Development & Innovation Manager (item 4.10 only)
Rachel Wright	PA to Group Chief Nurse (notes)

KEY

HUTH – Hull University Teaching Hospitals NHS Trust
NLAG – Northern Lincolnshire & Goole NHS Foundation Trust

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The Committee chair welcomed those present to the meeting. Apologies were noted from Paul Bytheway, Rob Chidlow & Nicky Foster.

1.2 Declarations of Interest

No declarations of interests were received in respect of any of the agenda items.

1.3 To approve the minutes of the meeting held on 24 April 2024

The minutes of the meeting were accepted as a true and accurate record.

1.4 Matters Arising

The Committee chair invited committee members to raise any matters requiring discussion not captured on the agenda. None were raised.

1.5 Committees-in-Common Action Tracker

The Committee approved the updates to the action tracker.

1.6 Operational pressures update

Kate Wood explained rotas were being regularly reviewed against the normal establishment during the junior doctors strike and all areas including ED were deemed to have safe staffing. There were significant overnight pressures across all hospital sites, however in the North bank ED on 26/06/24 they managed over 114 patients with 40 being acutely ill requiring in patient admission. The site team managed the operational challenges effectively.

2. MATTERS REFERRED

2.1 Matters referred by the Trust Board(s) or other Board Committees

The committee chair reported there were no matters referred.

3. RISK & ASSURANCE

3.1 Board Assurance Framework (BAF)

David Sharif confirmed there was no change to the BAF and work was still ongoing to refine the risk register and a more detailed report would be presented to the Committee at the next meeting.

4. COMMITTEE SPECIFIC BUSINESS ITEMS

<u>Joint Business Items</u>

4.1 Annual Quality Account

The paper was taken as read. Amanda Stanford explained stakeholder feedback was supportive of the quality priorities. The template will be reviewed prior to next year's report being produced. The Annual Quality Account was approved by the Committee.

4.2 Integrated Performance Report (IPR): quality & safety metrics

Following extensive discussions with governance and information teams around

gaps in data and the inability to report on quality priorities, Kate Wood and Amanda Stanford are facilitating a workshop on 3 July to agree how reports will look in the future. Kate wood will provide an update to the Committee at the next meeting.

Amanda Stanford added work was underway to ensure all incidents are captured and reported appropriately. Amanda Stanford added CDiff continued to be a challenge and this was something that was being experienced nationally post pandemic. Key priorities for IPC are to be agreed. Work continues around falls and falls with harm. Deep dive work was being undertaken in areas where higher numbers of falls were indicated. Amanda Stanford acknowledged the impactuful work undertaken by Jo Ledger and her team to reduce the number of falls at HUTH.

Kate Wood informed the Committee that a Never event (previously reported at Board) had been declared on the north bank following the misplacement of an NG tube and the patient had sadly subsequently died. The case has been reported to the coroner. A review of the process of reviewing Never events will be undertaken across the group to ensure consistency.

Jonathan Lofthouse asked whether the performance reports from the two sovereign sites (HUTH & NLAG) were compliant and whether data had been lost. Kate Wood explained NLAG was previously compliant and HUTH'S report was compliant but the report didn't contain the required level of detail relating to the quality priorities. Kate Wood added that during the Lorenzo implementation on the south bank, there had been a loss of access to BI reports due to the insource data warehouse issues.

Jonathan Lofthouse asked whether the process to take x-rays after the insertion of an NG tube was followed at both HUTH & NLAG. Kate Wood confirmed this was not the national guidance and this was not the standard approach at either HUTH or NLAG. The national guidance was to undertake a PH test and if the result of the test showed acidic then the tube was confirmed to be correctly sited. A review of documentation was being undertaken as part of the incident review. Michela Littlewood advised the investigation found a national document advising the PH test was problematic for all hospitals. Jonathan Lofthouse asked what the rationale was for having a clinical product that wasn't available across the different sites; Michela Littlewood confirmed the results of a product trial should highlight this.

Kate Truscott asked what the timeframe was to achieve compliance with the alert around bed rails. Richard Dickinson explained there were a number of issues including a legacy issue on the south bank relating to tracking and ensuring risk assessments are completed for all patients. A new draft policy (in hospital) has been completed and was going through approval processes. Jo Ledger added an analysis of the number of beds needed for compliance had been completed but there were delays with the manufacturer. Jo Ledger added mitigations to manage the risks would be put in place.

Kate Truscott shared concern about infection control on NICU. Amanda Stanford confirmed a deep dive would be completed and has spoken to the NICU team who are working on an action plan. Amanda Stanford will feedback to the Committee at a future meeting.

Stuart Hall highlighted the Never event process at HUTH. Kate Wood explained the policies will be aligned across the group to ensure a consistent approach.

Sue Liburd asked what mechanisms were in place to ensure the Committee received assurance on patient complaints. Amanda Stanford confirmed the mechanism would be discussed and agreed at the IPR time out and a more triangulated report would be presented. Jonathan Lofthouse added alignment of processes was complex in nature due to the differing reporting styles on the North and South banks and adding benchmarking for comparable institutions would help to contextualise the process.

David Sulch asked if MRSA blood stream infections had been reviewed and whether there were any themes. Amanda Stanford explained she had met with Debbie Wearmouth, Consultant Microbiologist and had discussed antimicrobial stewardship with the Chief Pharmacist and there would be an MRSA workstream commencing in the coming months and it will likely form one of the key priorities going forward. In the shorter term there is a focus on neonates due to their vulnerability.

4.3 CQC Improvement Plan

4.3.1 HUTH CQC Improvement Plan

Michela Littlewood explained some of the actions had been re-rated and dates reset and there was a plan to review all CQC actions across the group. Tony Curry asked for the reason to be added when dates are reset. Jonathan Lofthouse added the lack of progress on CQC actions was unacceptable and would arrange a task and finish group to address this.

David Sulch asked for an update around mechanical thrombectomy; Kate Wood explained there was no regional update but locally mechanical thrombectomy continued to be provided Monday to Friday, 9.00 am – 5.00 pm. Meetings are being held to discuss expanding hours regionally. Jonathan Lofthouse confirmed the issue would be raised at executive level and Kate Wood would feedback to the Committee. Ashok Pathak asked whether medical workforce was an issue; Jonathan Lofthouse felt there were vulnerabilities in workforce and that options were being explored.

The Committee agreed they were ‘not assured’.

4.3.2 HUTH Maternity CQC Improvement Plan and S31 Update

Amanda Stanford informed the Committee there had been a focus on redesigning governance structures over the last few weeks. Weekly MIS (Maternity Incentive Scheme) Year 6 and CQC meetings were now being held reporting directly into the monthly Maternity Assurance Committee. Work on the triage model continues particularly around plans overnight. The area of concern was around training. Although improvements are being seen in mandatory training compliance, further improvement was needed on maternity specific training ie, PROMPT, fetal monitoring. The main risk to achieving was current staffing levels. Plans were being put in place to align PROMPT training across the Group. Jonathan Lofthouse asked when the triage proposal would be available; Yvonne McGrath confirmed a task and finish group had been set up to explore the issues and

determine what additional resource was needed. Jonathan Lofthouse asked for a first stage triage proposal to be available by the end of July.

Kate Truscott raised concern around the delayed appointment of an audit lead. Amanda Stanford confirmed there had been a delay in getting the funding but the posts were now on TRAC. The team are also undertaking a service level review of PMRT, audits, MIS Year 6, guidelines etc. A leadership review was underway and an interim head of midwifery will be appointed whilst substantive recruitment is completed.

Stuart Hall understood that maternity reporting mechanisms were being reviewed for the Committees in Common and Trust Board. Amanda Stanford confirmed the new report would follow the national template and contain the appropriate metrics. A further report will also come from the Maternity Assurance Committee to consolidate MIS Year 6 and the 3-year improvement plan.

David Sulch highlighted the assurance framework had changed to the 'BRAG' (Blue, Red, Amber, Green) system in the general CQC action plans, but not in the maternity CQC action plan. Kate Wood confirmed the new system was gradually being introduced across all assurance.

The Committee agreed limited assurance.

4.3.3 NLAG CQC Improvement Plan

Richard Dickinson explained the heads of compliance have worked to align documents and ensure actions are allocated to the appropriate people within the new care group structure. .

Referring to the report, Kate Truscott queried whether 'no update since last report' meant there had been no actions; Richard Dickinson explained there were a number of meetings held in a 4-week period and it was dependent on how many meetings actually went ahead. Kate Wood added to take into account that staff were adapting to new processes.

Kate Truscott asked whether disbanded ultrasonography project (p9 2022 MAT18) had been replaced with a different project. Kate Wood confirmed she would seek a response out of the meeting.

Sue Liburd asked for further clarity on action 2019 19P (service should ensure that medical staffing are completing records accurately, in line with guidance) and asked for assurance the action was being progressed. Amanda Stanford confirmed that there would be a review of all CQC standards. Tony Curry felt some of the dates were unrealistic and dates should be reset and the reason the action wasn't being achieved documented.

The Committee agreed they were 'not assured'.

4.4 Maternity & Neonatal Assurance Reports (including Ockenden, CNST, MIS, incidents/MNSI

<u>HUTH</u>

The paper was taken as read. Amanda Stanford confirmed workforce continued to

be a significant risk with approx. 34 vacancies; 24 midwives are due to commence in September with discussions ongoing around the impact on skill mix. A robust educational and pastoral plan is being planned for the new midwives. The risks to achieving MIS Year 6 relate to training; Saving Babies Lives 3 remains challenging and requires good oversight from the clinical team. Teams at HUTH and NLAG have agreed a joint quality improvement project to support MIS Year 6. Neonatal services have been challenged lately due to acuity levels. Work is ongoing to strengthen the relationship with the MNVP (Maternity & Neonatal Voices Partnership). A review of neonatal deaths will be completed and all deaths over the past 12 months will be reviewed; the findings will be presented to the Committee at a future meeting.

Yvonne McGrath highlighted data quality issues with BadgerNet were a risk to achieving Safety Action 2 although it was anticipated to be a national problem. Jonathan Lofthouse shared concern that BadgerNet had been installed under separate licenses on the individual sites which would impact on maintenance costs in the future. Kate Wood added IT teams across the ICB were not involved in the Badgernet decision making process.

Tony Curry asked for assurance on how the proposed changes in maternity would be embedded and whether they were sustainable. Amanda Stanford explained the team were working towards a strategic vision for maternity services which would include work around culture. A series of listening events for maternity have been arranged over the next 2 weeks. A group will also visit Lewisham and Grenwich Trust who have come out of maternity special measures.

<u>NLAG</u>
Workforce remained a risk as per the national picture. Maternity apprenticeships will be considered as part of workforce plans across the Group. A concern around a PMRT case impacting on MIS Year 6 delivery has been resolved. NLAG have now exited the Maternity Services Support Programme (MSSP) and the team will continue to improve and embed practice. Yvonne McGrath added 70 pieces of positive feedback had been received and newly qualified midwives recruited which would impact positively on the vacancy position. Results of the Birthrate Plus audit will be presented at Trust Board in December. Referring to NLAG's exit from MSSP, Sue Liburd voiced a degree of concern that South bank maternity services improvements may degrade having left MSSP due to a number of leadership factors and the group focus on North bank Section 31 requirements. Her concerns were recognized and acknowledged. Sue was supportive of the new maternity governance structures and was reassured NLAG remained an equal priority. A review of maternity and neonatal safety champions across the Group is being prioritised.

Kate Truscott highlighted the reported stated that data couldn't be obtained from Power BI; Yvonne McGrath explained that the systems had changed and data should be accessible for next month's report.

The Committee agreed limited assurance.

4.6 Children & Young Peoples' Assurance Report

The paper was taken as read. Debbie Bray highlighted the ongoing review into neonatal and paediatric surgical services, predominantly focusing on HUTH but

also incorporating NLAG. The report is due for completion at the end of August and will be presented to the Committee. Any immediate risks would be mitigated at the point they are identified. Work continues on the deteriorating child workstream focusing on PEWS and sepsis. The national roll out of national PEWS has been well embedded in HUTH and NLAG; the team are reviewing the audit to enable robust reporting of compliance against the revised tools. The new sepsis e-learning training went live on 27/06/24 and will support staff around sepsis. The assurance mapping exercise around neonatal services in HUTH has been completed and the factually accurate checked report will be resubmitted to NHS England. A workforce review of neonatal services at HUTH will be presented to the Committee in September.

Jonathan Lofthouse queried why the improvement plans (referred to on page 3 of the assurance report) had not been updated since 2020 and how this was being addressed. Debbie Bray acknowledged the deteriorating position in some elements and explained an original exercise was undertaken at HUTH and NLAG prior to the Covid pandemic and was a highly prioritised workstream at NLAG forming part of the Children and Young People's Strategy. Progress with Facing the Future had been limited at HUTH. The main barrier related to workforce which will now form part of a core work plan to get Facing the Future moving forward again.

Jonathan Lofthouse felt the medication errors were quite high and was concerned that this may be being tolerated. Debbie Bray explained the medication errors were focused on neonatal services at HUTH and on the Grimsby site. The team will be working with pharmacy and medical colleagues to undertake a deep dive and the findings will be shared in the next report. A number of actions are already being taken around carrying out 'druggles' (safety huddle focused on medication) and ensuring staff are aware of incidents. A lack of dedicated pharmacy support into the neonatal service will be reviewed as part of a workforce plan. Kate Wood added the severity of the medication errors were low and no harm and there was a strong culture of reporting. The Committee requested an update on medication errors at a future meeting.

Action – Debbie Bray to review medication errors and report back to the Committee.

The Committee agreed limited assurance.

4.7 PSIRF/Serious Incidents (including Duty of Candour and lessons learned)

Richard Dickinson explained 6 serious incidents were being tracked by NLAG. HUTH and NLAG PSIRF processes became fully aligned on 17/06/24 and thematic reviews were ongoing. Duty of candour training sessions are also planned. David Sulch asked that the audiology actions were captured in one place and there is evidence of an effective change as a result of an intervention from training.

The Committee agreed reasonable assurance.

4.8 Quality Impact Assessment (QIA)

4.10 Research, Innovation & Development Quarterly update

The paper was taken as read. James Illingworth explained the team were developing a group research and innovation strategy which will align governance, finance and engagement activities across the patch. The strategy was due to be available in September. James Illingworth highlighted commercial activity was heavily weighted to HUTH and the team aspired to grow commercial research activity and associated income across the NLAG patch. Patient experience survey responses were behind track for Q1 but the team are using more targeted promotion to get responses from patients. The department have been selected for the cancer vaccine launchpad programme enabling patients a treatment option through research for a personalised vaccine with the first study for colorectal study expected by mid-August. £180,000 of additional investment over 3 years has been secured to support delivery of the cancer vaccine programme. Other achievements included plans to develop a workforce strategy with a focus on the creation of more academic posts with a potential for nursing, midwifery and allied health professionals. A celebration event will be held planned to showcase activities across the group. An increase in colleagues wishing to increase their research activity was noted.

Amanda Stanford added it was important the research strategy for nursing, midwifery and AHPs linked to the forthcoming nursing, midwifery and AHP strategy.

Ashok Pathak explained a number of local firms previously funded research programmes on the North bank and suggested contacting these companies for funding support. James Illingworth confirmed there were close ties with Smith and Nephew but they tended to link with companies out of the local area.

Ashok Pathak also asked how many research papers were being produced and in which specialty and whether academic posts were still being recruited to. James Illingworth confirmed the team were part of a joint academic planning group with the University of Hull and Hull York Medical School. In terms of research papers this information would be included in future reports.

Kate Truscott asked when selecting research proposals whether areas of risk were considered. James Illingworth explained the Clinical Research Network periodically mapped disease prevalence so there was a joint approach. Referring to the workforce strategy, Kate Truscott asked whether the resources were in place to support all staff groups. James Illingworth explained there were various peer to peer groups enabling staff to be identified early and the team were looking to introduce a question on research at all PADRs.

Kate Wood acknowledged the work undertaken to combine the teams into a group and felt there needed to be a balance between developing the service whilst achieving CIP targets.

Sue Liburd asked whether the Ethnic Minority Research Inclusion (EMRI) hub played an integral role in engagement and promotion of research. James Illingworth explained a staff member worked alongside EMRI and provided the link with communities.

The Committee agreed reasonable assurance.

4.11 Learning from Deaths 2023/24 Q4 Report

Kate Wood explained a learning from deaths policy was being developed with an overarching strategic intent; the policy would be presented at the Mortality Improvement Group for approval. David Sulch highlighted that palliative care coding was lower at NLAG; Kate Wood confirmed this was because additional palliative care input was required across the South bank. Richard Dickinson added work was being undertaken on how quality care data was captured. Referring to deaths from people with learning disabilities, Sue Liburd asked how confident the team were that the areas identified would improve. In terms of lack of evidence for mental capacity assessments, Kate Wood confirmed this was now a quality priority. There will also be a focus on recognition of end of life.

The Committee agreed reasonable assurance.

4.12 Audiology Services CQC Response

Referring to the report, Kate Wood highlighted that item 4.12 was a mandated assessment sent to all Trusts delivering audiology services. Five key lines of enquiry were sent to organisations and the report detailed the responses provided to the CQC. The biggest risks for HUTH and NLAG were capacity around accommodation, equipment and staffing. Item 4.13 related to serious incidents at NLAG and low reporting of children with permanent childhood hearing impairment. The proposed next steps in the report have been considered by Cabinet who have confirmed a single service going forward. A total of 62 children had been identified so far and each one will be sent an outcome letter and a copy of the SI report; it is anticipated there would be media interest at this point.

Ashok Pathak highlighted the recommendation that children are seen within 6 weeks of referral. Kate Wood added external support was still being provided including from Medinet. Patients or consultants would not be expected to travel and options on how best to deliver the service were being explored. Tony Curry asked whether the right levels of skill and expertise were in place to deliver the service and it why it was anticipated to take 2 to 3 years to resolve the issues. Kate Wood gave an overview of some of the difficulties highlighting the capacity to take on staff and re-training. Whilst there had been some investment for facilities on the North bank the team were viewing what was actually needed as part of a refreshed approach. Kate Truscott acknowledged the team who had the challenging task of contacting the families and delivering the difficult news and asked what the future governance arrangements would be. Kate Wood confirmed ultimately there would be an escalation route to the Quality and Safety Committee at a timeframe to be agreed. Sue Liburd asked what support was being provided by the ICB and what the potential financial implications were; Kate Wood confirmed there had been one claim against the Trust but there were significant reputational costs and stressed the response would reiterate the Trust had made a grave error wholeheartedly apologising for any harm caused. Support was also being provided to the head of audiology.

?? asked why issues were not raised through internal mechanisms; Kate Wood felt there hadn't been the right level of scrutiny due to lack of knowledge and training and it was important that concerns were raised when they are highlighted; support from the national team had also been expected sooner.

Weekly meetings were in place to focus on patients and the other around team development and operational activity. Setting clear performance measures would support the team to measure and monitor the data. Kate Truscott added it was important the organization remain cited and that systems and processes were in place to ensure the right people were being employed (clinical and no clinical) and the right training provided. Kate Wood confirmed the lessons learned were being spread across the care groups and a quarterly monitoring process has been implemented for screening.

David Sulch asked whether there could be similar issues affecting other small, under the radar services. Amanda Stanford confirmed that there could be.

The Committee agreed limited assurance.

4.13 External Review of Audiology Services
See item 4.12.

NLAG Specific Business Items
There were no specific business items discussed.

HUTH Specific Business Items
There were no specific business items discussed.

5. STRATEGY

5.1 Medicines Management Annual Report
The report was taken as read. Kate Truscott asked whether apprenticeships were available in pharmacy. Simon Priestley confirmed apprenticeships were used for pharmacy support workers and technicians. Jo Goode explained the ICS were looking at registration of overseas pharmacists. Ashok Pathak was aware patients had experienced delays in medications being available and were waiting several hours to collect medication and how this was being addressed. Joanne Goode explained there had been issues with Lloyds but they were now meeting their KPI for waiting time (30 minutes). Deliveries are also being offered where there are supply shortages. Improvements are being worked through including one stop dispensing (as per NLAG) and the recruitment of a dispensary co-ordinator has enabling faster discharges. Simon Priestley added over label packs were available on wards at NLAG meaning the majority of medications were prepared in advance; Lloyds also meet their KPI. There is no delivery service at NLAG.

Tony Curry asked if there were longstanding bugs in the electronic prescribing systems and how they could be resolved. Simon Priestley HUTH and NLAG systems were part of the group's digital programme and there was likely to be a common EPMA in the future. Issues with medicines reconciliation data since the Lorenzo installation were being worked through; there has been no increase in the number of safety incidents. Jo Goode added issues at HUTH with Lorenzo EPMA product alert notices were on the risk register. Amanda Stanford asked what the impact of time critical delays were as these were generally under reported and what assurance measures were in place. Simon Priestley had no concerns with harm around time critical medicines at NLAG and confirmed missed or delayed doses were shared daily with the pharmacy team. Parkinson's medication was now available in ED as a gap had been identified previously. Jo Goode had no

concerns at HUTH and a delayed medicines report was being developed within Lorenzo.

Amanda Stanford asked what performance was like between the IV to Oral switch. Jo Goode confirmed performance was improving at HUTH which supported good CQUIN results. Simon Priestley added the CQUIN was achieved at NLAG but further work was still needed to improve further.

Referring to the 2023 CQC Report around controlled drugs management, Amanda Stanford asked whether the policy that was implemented had changed practice and if this had been audited. Jo Goode explained new controlled drug registers had been implemented in Theatres and Jo received assurance from the Controlled Drugs Annual Report.

Sue Liburd shared concern that the NLAG Medicines and Therapeutics Group had only met 6 out of a possible 12 planned meetings. Simon Priestley confirmed that strikes impacted on colleague availability and he was working with Jo Goode to combine the HUTH and NLAG meetings and this would link into a planned single ICS area prescribing committee.

Sue Liburd highlighted that NLAG had the highest percentage of antibiotic use within the 'watch aware' category; Simon Priestley confirmed the reasons were historical and related to an antibiotic called co-amoxiclav and concerns around the use of alternatives not being monitored and managed effectively. NLAG was now working with HUTH on strategies to take this work forward.

The Committee agreed limited assurance based on digital issues with pharmacy.

5.2 Medication Safety Annual Report
See item 5.1.

5.3 Clinical Audit Annual Report
This item was deferred to the next meeting.

6. ITEMS FOR INFORMATION/TO NOTE

6.1 Hull TAVI clinical records review
Kate Wood explained a number of different internal and external investigations had been carried as a result of the TAVI service one being a clinical record review looking at deaths. Kate Wood asked for TAVI to be discussed in more detail at a future meeting which was supported by the Committee.

7. ANY OTHER URGENT BUSINESS
No other urgent business was discussed.

8. MATTERS TO BE REFERRED BY THE COMMITTEES

8.1 Matters to be Referred to other Board Committees
No matters were referred.

8.2 Matters for Escalation to the Trust Boards

It was agreed that the following matters required escalation to the Trust Board(s) in the committees' highlight report:

a) The CIC approved the Quality Accounts following delegated responsibility from the Boards in Common.
b) The CIC received the Audiology CQC submission on behalf of the Trust Board
c) A Task and Finish Group to be established to review the outstanding CQC actions across the Group. This would be chaired by Jonathan Lofthouse. Progress against actions would continue to be monitored at the CICs.

9. DATE AND TIME OF THE NEXT MEETING

Wednesday 31 July 2024, 09.00 – 12.30 via MS Teams

Cumulative Record of Attendance 2024

			Jan	Feb	Mar	Apr	May	Jun
Core Members								
Una Macleod	UM	Non-Executive Director (HUTH)						
Sue Liburd	SL	Non-Executive Director (NLAG)						
David Sulch	DS	Non-Executive Director (HUTH)						
Ashok Pathak	AP	Associate Non-Executive Director (HUTH)					DNA	
Kate Truscott	KT	Non-Executive Director (NLAG)						
Tony Curry	TC	Non-Executive Director (HUTH)					DNA	
Kate Wood	KW	Group Chief Medical Officer	CH				PS	
Shaun Stacey	SS	Group Chief Delivery Officer	AA				NR	
Paul Bytheway	PB	Interim Group Chief Officer						
Amanda Stanford	AS	Group Chief Nurse Officer	MS		MS			

Attended	Apologies/Deputy sent	DNA

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)157

Name of the Meeting	Trust Boards-in-Common (meeting held in Public)
Date of the Meeting	08 August 2024
Director Lead	Kate Wood, Group Chief Medical Officer
Contact Officer/Author	Joanne Goode, Chief Pharmacist (HUTH) Simon Priestley, Chief Pharmacist (NLAG)
Title of the Report	Annual Medicines Optimisation Report 2023/2024
Executive Summary	The Annual Medicines Optimisation report provides an account of medicines management and optimisation activities undertaken over the last year. It is intended to update the Board on the Trust's medicines optimisation arrangements, outlining progress made in year, as well as the key areas of concern and plans going forward for the next year. Key achievements: Recruitment within the pharmacy team on the NLaG site. On trajectory for majority of posts being filled by October 2024. Achieved the Commissioning for Quality and Innovation framework linked to the implementation of the discharge medicines service to improve patient outcomes by collaboratively communicating with community pharmacies about medicines when patients transfer to a different care setting for a second year. Establishment of the first consultant pharmacist posts at HUTH for Haematology and Antimicrobial Stewardship and Infectious Diseases. Key areas of concern: Medicines Reconciliation within 24 hours of admission across the group remain below expected levels, impacted by challenge arising from pharmacy vacancies. Antimicrobial usage at NLaG. Lorenzo ePMA concerns around product alert notices, reporting functionality and integration with other systems at HUTH. Key plans for next year: Review the underlying Key Performance Indicators in this report and standardise across the group. Medicines Management Nursing team to lead on improving Safe and Secure storage of medicines KPI using Quality Improvement methodology at NLaG. Support work to progress a single system Area Prescribing Committee and single formulary approach to tackle inequality in the current system. Share learning on successful antimicrobial strategies to ensure appropriate prescribing and use at NLaG.

	Prepare for changes to the Foundation Trainee Pharmacist programme by increasing the number of pharmacists eligible to become Pharmacist Designated Prescribing Practitioners.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Quality and Safety Committees-in-Common meeting held on 27 June 2024
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Medicines Optimisation

Annual Report

2023/24

Joanne Goode and Simon Priestley

Chief Pharmacists HUTH and NLaG

June 2024

Executive Summary

The Annual Medicines Optimisation report provides an account of medicines management and optimisation activities undertaken over the last year. It is intended to update the Board on the Trust's medicines optimisation arrangements, outlining progress made in year, as well as the key areas of concern and plans going forward for the next year.

Key achievements:

- Recruitment within the pharmacy team on the NLaG site. On trajectory for majority of posts being filled by October 2024
- Achieved the Commissioning for Quality and Innovation framework linked to the implementation of the discharge medicines service to improve patient outcomes by collaboratively communicating with community pharmacies about medicines when patients transfer to a different care setting for a second year
- Establishment of the first consultant pharmacist posts at HUTH for Haematology and Antimicrobial Stewardship and Infectious Diseases

Key areas of concern:

- Medicines Reconciliation within 24 hours of admission across the group remain below expected levels, impacted by challenge arising from pharmacy vacancies
- Antimicrobial usage at NLaG
- Lorenzo ePMA concerns around product alert notices, reporting functionality and integration with other systems at HUTH

Key plans for next year

- Review the underlying Key Performance Indicators in this report and standardise across the group
- Medicines Management Nursing team to lead on improving Safe and Secure storage of medicines KPI using Quality Improvement methodology at NLaG
- Support work to progress a single system Area Prescribing Committee and single formulary approach to tackle inequality in the current system
- Share learning on successful antimicrobial strategies to ensure appropriate prescribing and use at NLaG
- Prepare for changes to the Foundation Trainee Pharmacist programme by increasing the number of pharmacists eligible to become Pharmacist Designated Prescribing Practitioners

Recommendation to the Board

This report is presented for the Board's approval.

Medicines Optimisation Annual Report 2023/24

1. Introduction

The purpose of this report is to:

- Provide assurance to the Board that medicines are managed appropriately and effectively throughout the organisation.
- Summarise the activities and achievements relating to medicines optimisation undertaken over the last year
- Highlight the progress and areas for development with regards medicines optimisation

Following the creation of a Group operating structure, this paper aims to draw together several items previously reported separately across Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG). There are no national standards guiding the content of an Annual Medicines Optimisation report meaning different information has historically been reported in each Trust. Similarly a number of measures are not directly comparable due to differences in data collection. One of the key aims for the year ahead is to review each measure and underlying standards so there are a single set of meaningful Key Performance Indicators (KPI) in next year's report. This will include aligning work to address Quality Priorities.

2. Medicines Optimisation Strategy

A medicines optimisation strategy drives the organisation's approach to medicines optimisation. It provides the framework through which medicines optimisation is managed under the overarching framework of the Trust Clinical strategy.

Medicine optimisation is the term used to describe four important principles that focus on patients and outcomes, rather than symptoms and processes:

3. Clinical Effectiveness

3.1. Medicines and Therapeutics Group / Drugs and Therapeutics Committee

The role of the Medicines and Therapeutics Group (NLaG) / Drugs and Therapeutics Committee (HUTH) is to approve and monitor all policies and guidance concerning medicines management within the respective Trust and agree the Trust position on Humber Area Prescribing Committee business, which includes controlling and managing the entry of new medicines to the joint formulary.

In 2024/25 these will merge to provide consistent approach across the Group and unified position in the Humber Area Prescribing Committee.

The NLaG Medicines and Therapeutics Group met six times out of twelve planned meetings over the year 2023-2024, in part due to the impact of industrial action. The Chief Pharmacist wrote to the Divisional Medical Directors asking them to review and support attendance for their divisions. The HUTH Drug and Therapeutics Group met ten times over the year 2023-2024.

The move to a group operating model will result in a refresh of membership and help ensure attendance moving forward. Compliance with the formulary has been maintained across the group, ensuring patients are prescribed appropriate treatment.

3.2. Humber Area Prescribing Committee

Work to align formularies and shared care agreements has continued. Further support is required from the Integrated Care Board to address the historical inequalities arising from different funding models across the Primary Care Networks prior to the formation of Integrated Care System and the negative impact this has had on shared care.

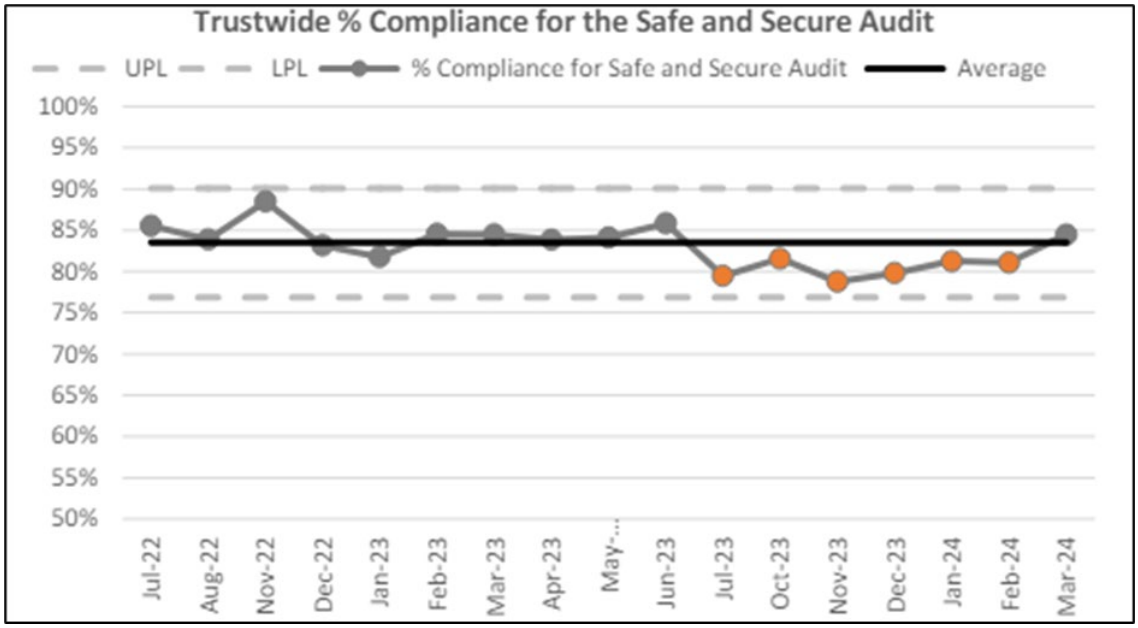
The Humber and North Yorkshire Integrated Care System have started discussions to look at a single system Area Prescribing Committee (APC) to bring together the Humber APC and North Yorkshire and York APC to further reduce unwarranted variation and inequality. We will continue to support this work.

3.3. Audit

Pharmacy led audits are being transferred across to the new Audit Management and Tracking (AMaT) system. This has several benefits, including improved visibility of results for ward managers and email notifications from within the system which will help improve ownership for developing action plans and accountability for their delivery by the correct teams.

3.3.1. Safe and Secure Handling of Medicines Audit (NLaG)

At NLaG, all wards and departments where medicines are stored are audited focusing on 11 priority standards. Due to staffing pressures we were unable to collect data for August and September 2023. There were no significant changes to overall compliance across the year with March 2024 overall being 84.5% against a 12 month average of 82%.



Priorities for 2024/25 are to improve the standards relating to medicines being stored in original packaging and ensuring ambient room temperature monitoring is being completed (the latter being a new standard introduced in the last 12 months).

The table below illustrates the overall Trust position at HUTH for 58 clinical areas in relation to all of the ward fundamental standards as of the 13th March 24 and the number of wards that are performing at each level. From the 4th September 23 to the 13th March 24 41 audits were completed by Practice Development Matron and Clinical Nurse Educator, there were no outstanding audits for this audit period. There are currently no areas rating red, with 20 areas showing an improvement in the audit scoring. Surgery health group and family and women's health groups showed the highest improvements.

Clinical Support		Family & Women's		Surgery		Medicine		Emergency Medicine		Cardiology Division	
March 24		March 24		March 24		March 24		March 24		March 24	
Current Position		Current Position		Current Position		Current Position		Current Position		Current Position	
2		1		2		4				1	
5		6		14		10		3		3	
		2		2		3					

3.3.2. Safe and Secure Storage of Controlled Stationary

At NLaG, audits continued to show that 100% of areas were compliant with the standard of controlled stationary being stored securely.

A policy for the security of FP10HNC prescription forms was approved at the April 2024 NLaG Medicines and Therapeutics meeting. This policy focuses on the security of FP10HNC prescriptions specifically as they can be dispensed via community pharmacy. Audits showed 90% of areas maintained a record of FP10HNC prescription forms.

Other secure stationary in use is only valid at the hospital inpatient or outpatient pharmacies and therefore less liable to diversion and misuse. To further mitigate risks of diversion and misuse all prescription forms require secure storage in a locked cupboard with an Abloy lock or a key under the control of the nurse in charge of the ward/department at NLaG (100% compliance reported as above).

At HUTH in 2023-2024 21 clinical areas that held FP10HNC were audited and no concerns were raised regarding safe storage and the speciality issued was checked and correct for the area.

3.3.3. Safe and Secure Storage of Controlled Drugs

At NLaG, audits continued to provide significant assurance relating to the Safe and Secure Storage of Controlled Drugs, with overall compliance at 96%.

Across 19 standards, 18 standards demonstrated over 85% compliance with 9 standards at 100% (an increase from 5 standards at 100% in 22/23). The main area of non-compliance continues to be with documentation, specifically crossing out and overwriting errors rather than using brackets and an explanatory note added. Implementation of an electronic controlled drug register across all areas would help eliminate human error, crossings out and miscalculation associated with the handwritten process as well as having potential to save nursing and pharmacy time if linked to electronic controlled drug ordering. Ideally this would be part of a strategy to implement electronic ward cabinets for the storage of medicines which would release nursing time and support a reduction in stockholding due to improved information and oversight.

At HUTH, the controlled drug audit standards differ from NLaG and of 17 standards measured, 14 are above the 80% adherence and 3 standards are between 70-80% compliant. 72% of areas had an up to date signature list for nurses authorised to order controlled drugs and 77% of opened controlled drug liquid bottles on wards included the date of opening and these are areas for improvement at HUTH. We will work to align these standards for future reports.

3.3.4. Medicines Reconciliation

The pharmacy service must ensure that medicine reconciliation is conducted in line with the National Institute for Health and Care Excellence Quality Statement 120 and audited in line with trust policy. The target is to undertake medicines reconciliation within 24 hours of admission for 80% of inpatients.

At NLaG, the Pharmacy service has continued to face significant workforce pressures which limited our ability to improve in this area. A trial to target the pharmacy service to admissions wards saw an increase in February from 37% to 47% within 24 hours and from 75% to 83% overall within the patients inpatient episode. We are reviewing whether the changes made are sustainable in the longer term. Due to the Lorenzo PAS switch we haven’t been able to get data since February 2024.

At HUTH there have been similar challenges in measuring and reporting medicines reconciliation performance on Lorenzo and Nerve Centre. Progress with this has been made and we will align our measuring and reporting system with NLaG moving forwards.

4. Medicines Safety

The role of the Safer Medication Group (SMG, NLaG) and Safe Medication Practice Committee (SMPC, HUTH) is to promote and support safer medication practice and provide assurance that the trust has in place the necessary controls to manage risk in relation to medication practice. It achieves this through its multi-disciplinary membership providing advice on the safe and effective use of medicines, sharing lessons from medication errors, seeking assurance from divisions on matters relating to medication safety and overseeing actions against recommendations outlined in National Patient Safety Alerts.

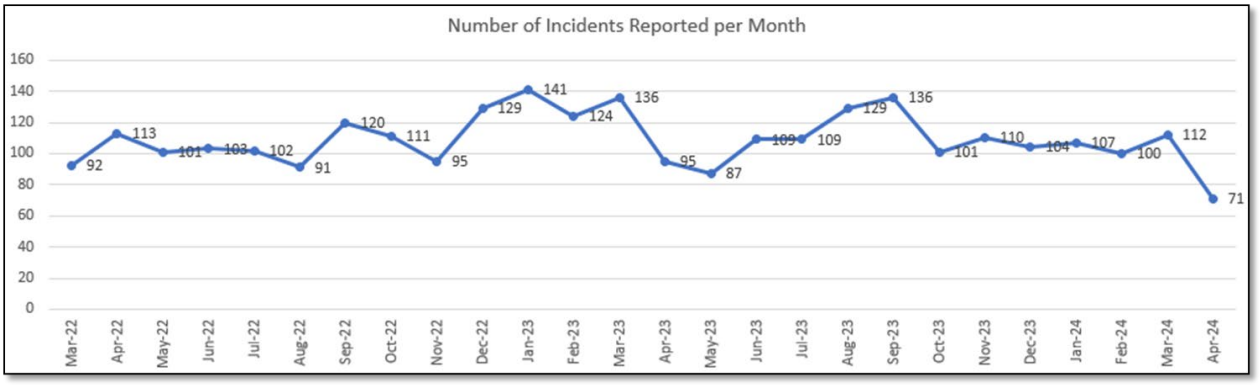
The SMG reported into the Quality Governance Group at NLaG and SMPC reported into the Quality Committee at HUTH.

The SMG met ten times out of twelve planned meetings in 2023-2024. The improvement in overall engagement and attendance seen last year has been maintained. The SMPC met six times out of six planned meetings in 2023-2024.

Both organisations have a Medicines Safety Officer (MSO) and they engage in the regional and national MSO groups and share learning across the group.

4.1. Medicines Incidents

NLaG medicine incident monthly reporting fluctuated in line with natural variation in 2023-2024, similar to 2022-2023.



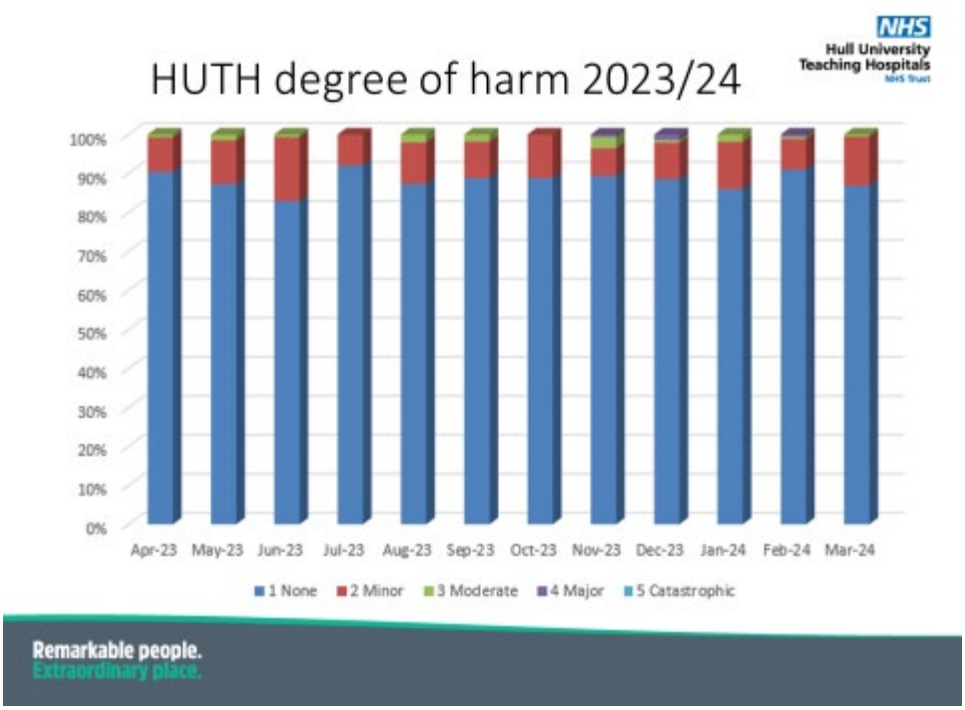
There were 1300 reported medication incidents in NLaG. The majority of reported incidents (99.6%) were near miss, no harm or low/minor.

There was one patient death relating to a medication incident which is subject to ongoing police investigation. Appropriate learning has been shared following initial rapid review and staff supported as appropriate.

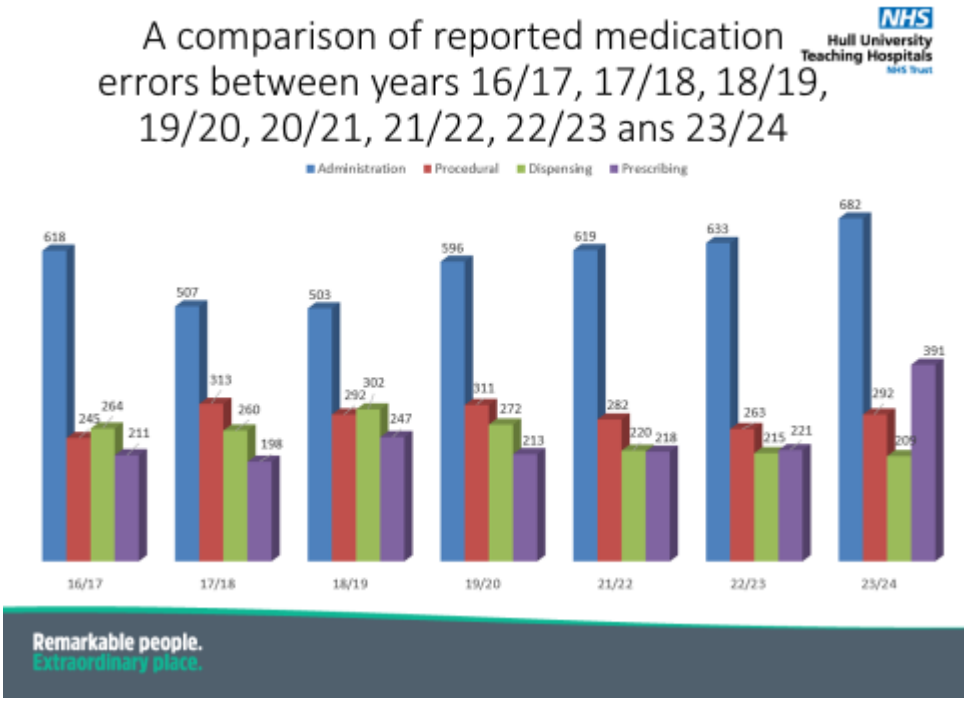
The top 3 categories of incident in NLaG relate to administration (34%), prescribing (25%) and storage (19%).The top 3 medication categories relate to analgesia (22%), antibiotics

(11%) and anti-epileptics (7%).

In HUTH there were 1574 reported medication incidents. There were no catastrophic incidents in this reporting period and the majority of incidents were near miss, no harm or low/minor.



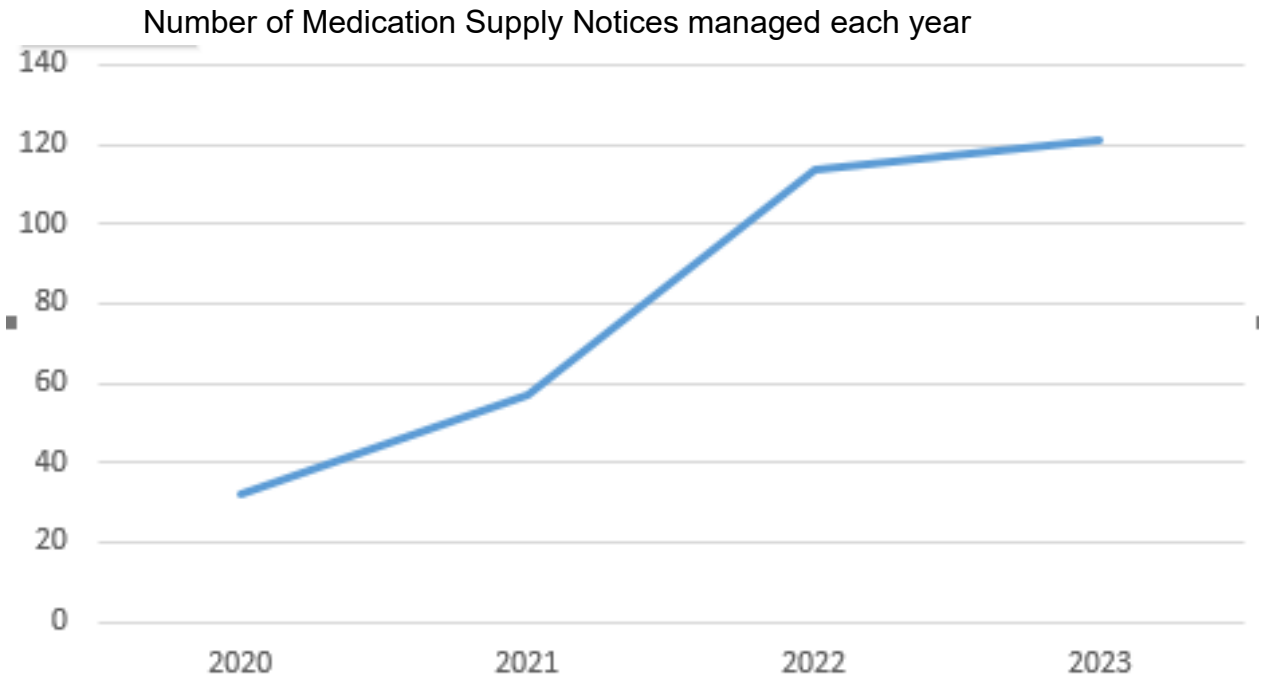
The top 3 categories of incident in HUTH relate to administration (43%), prescribing (25%) and procedural (19%).



The Pharmacy teams at both HUTH and NLaG actively encourage reporting of incidents to maximise the opportunity for shared learning and improvement from near misses. The

expectation is that as overall reporting increases the proportion of incidents causing harm will decrease.

HUTH and NLaG are working collaboratively to manage national medication shortages across the group and minimise the impact on our patients. There were 121 medication shortages managed in 2023-2024 and this number has been increasing each year.



4.2. Controlled Drugs

All healthcare organisations are required to promote safe and secure use of controlled drugs and ensure compliance with relevant legislative and regulatory requirements. A quarterly audit is conducted at all sites in NLaG with action plans implemented where necessary. At HUTH these audits are carried out every six months. The Chief Pharmacists at HUTH and NLaG are the Accountable Officers for controlled drugs and they attend and share learning with the regional and national controlled drug intelligence networks.

Quarterly occurrence reports of controlled drug incidents were submitted to NHS England Controlled Drug Accountable Officer in accordance with regulatory requirements.

In NLaG, Trust assurance is reported via the Safer Medication Group which reports to the Quality Governance Group. In HUTH there is a monthly Accountable Officer Controlled Drug meeting which reports into Safe Medicines Practice Committee.

In NLaG, in 2023-2024 a total of 290 incidents were reported relating to controlled drugs, an increase from 2022-2023 total of 208. The categorization for reporting changed at the beginning of the year, introducing a no harm option where previously the lowest reporting patient harm category was low. No incidents were rated moderate or above, with 86% no harm and 14% low harm.

The largest category of reported incidents in NLaG relate to Governance (errors in record keeping and minor policy deviation) which accounted for 46% of incidents. Progress continues to be made addressing lost controlled drugs (19% of incidents) with an increase in the number accounted for upon investigation (39% vs last year 30% of lost controlled drugs accounted for following investigation).

In HUTH, in 2023-24 there were 258 controlled drug related incidents, an increase from 244 the previous year. No incidents were rated moderate or above, with 97% no harm and 3% rated as low harm.

The largest category reported in HUTH are medication procedures 53%. Medication administration errors account for 31% and dispensing errors 9%. The controlled drug annual report and recommendations were presented to SMPC in May 2024.

The CQC inspection for HUTH in 2023 made a recommendation for improving management of controlled drugs in theatres. A new policy was developed for use in HUTH theatres and a new controlled drug register was introduced to support the additional checks required to record booking out and record all waste.

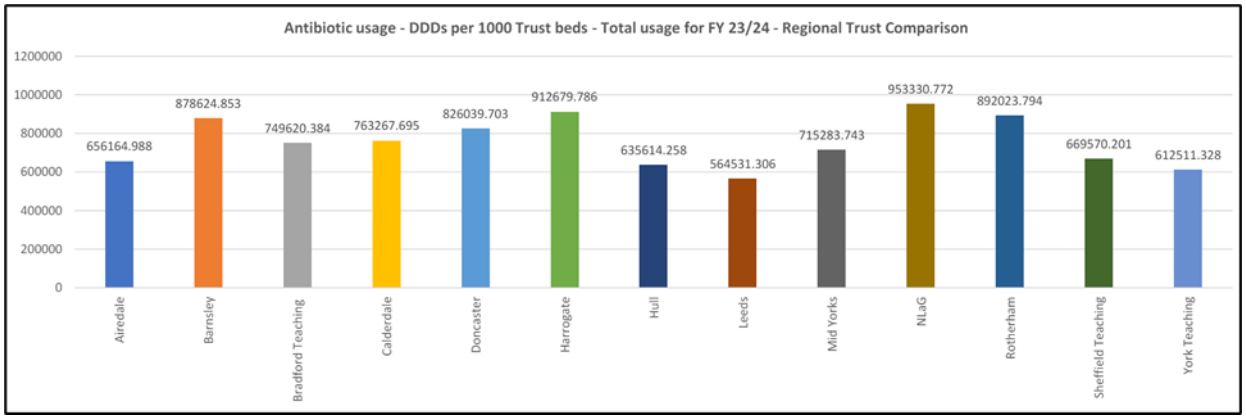
4.3. Antimicrobial Stewardship

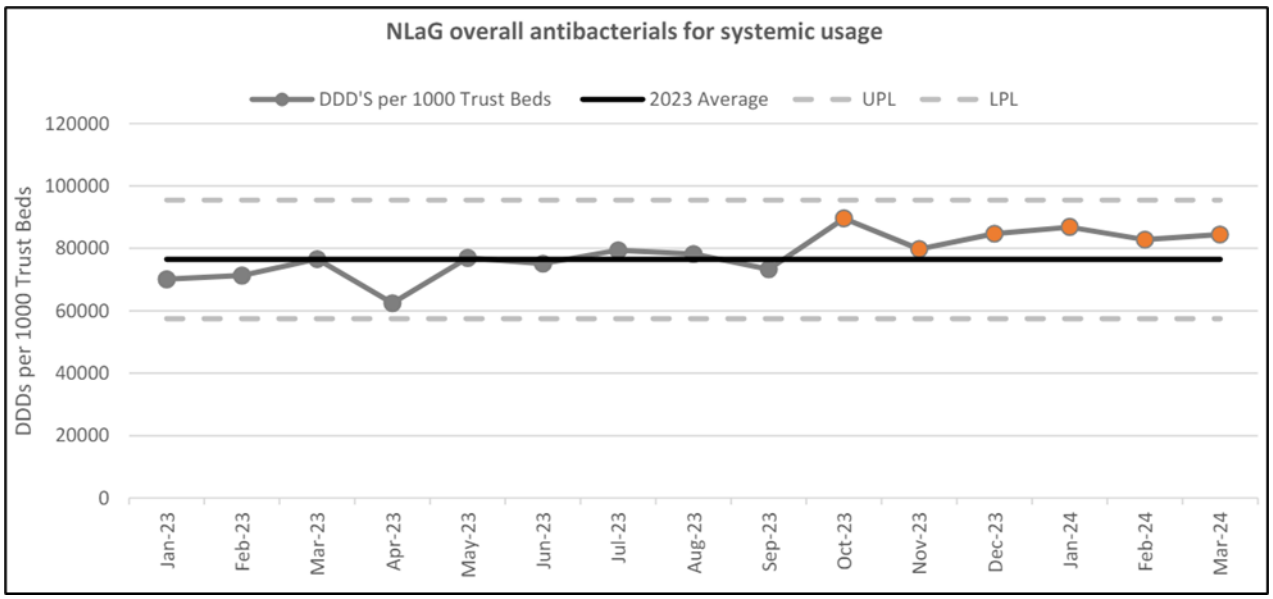
Antimicrobials stewardship is defined as 'an organisational or healthcare-system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness' (National Institute for Health and Care Excellence guideline NG15, 2015). It is therefore an important part of Medicines Optimisation.

The Trust's Antimicrobials Stewardship Strategy incorporates all elements of the national 'Tackling Antimicrobial Resistance 2019–2024: The UK's five-year national action plan'. This was the first 5-year plan as part of the 'UK's 20-year vision for antimicrobial resistance' published in 2019 which set the ambitious goal to ensure antimicrobial resistance will be controlled and contained by 2040. The second 5-year action plan for antimicrobial resistance 2024 to 2029 was published in May 2024. The Trust's strategy will be reviewed in light of this and updated accordingly.

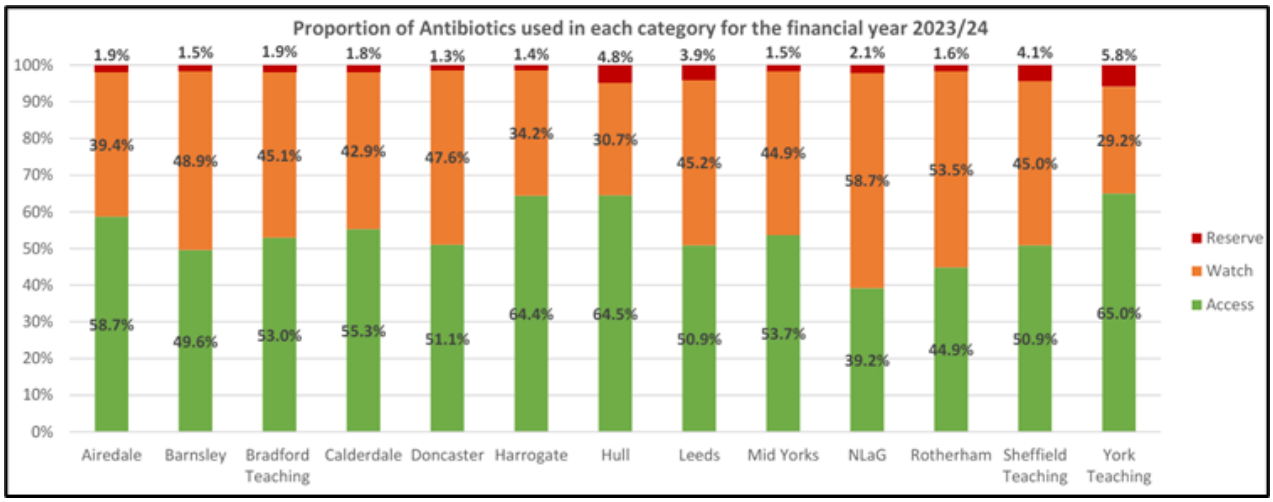
The NLaG Consultant Pharmacist for Antimicrobials resigned towards the end of the year. A Pharmacist has been appointed (subject to recruitment checks) and will commence in role towards the end of 2024. This is a key role, working with Microbiologists and Clinicians to deliver improvements in Antimicrobial Stewardship across the Trust.

When compared with other Trusts across our region, NLaG is the highest user of antibiotics as measured by Defined Daily Dose (DDD) per 1000 beds. Usage is on an upward trend (although statistically within normal variation range), despite efforts to reduce overall antibiotic usage. HUTH uses approximately one third less DDD per 1000 beds. This is a significant area for shared learning and collaborative work for the year ahead.





NLaG also have the highest % of antibiotic use within the Watch AWaRE category, these should be prioritised as key targets of stewardship programs and monitoring as they have a high risk with regards antimicrobial resistance.



HUTH appointed to its first accredited consultant pharmacist post for Antimicrobial Stewardship and Infectious Diseases in 2023. The post holder is accrediting as an individual for consultant pharmacist through portfolio with the Royal Pharmaceutical Society.

MicroGuide is an app that clinical staff can access antimicrobial guidelines easily on their smartphone or laptop. This was implemented and widely promoted across HUTH clinical teams and a task and finish group chaired by the HUTH Chief Nurse successfully worked together to improve antimicrobial stewardship with multidisciplinary team working.

5. Commissioning for Quality and Innovation (CQUIN)

Pharmacy teams supported two CQUIN schemes in 2023/24, achieving both.

Indicator	Financial / Non-financial	Min	Max	Q1	Q2	Q3	Q4	Full year performance	Q1	Q2	Q3	Q4	Full Year performance
CQUIN04 Prompt switching of intravenous to oral antibiotic (Target: Lower is better)	Non-financial	60%	40%	32%	37%	38%	33%		13%	20%	12%	23%	
CQUIN06 Timely communication of changes to medicines to community pharmacists	Financial	0.5%	1.5%	1.07%	1.53%	1.46%	1.57%		2.34%	3.39%	4.15%	3.51%	

6. Benchmarking Pharmacy Services

The Trust continues to participate in the annual NHS Benchmarking Networks Pharmacy and Medicines Optimisation. The aim is to compare pharmacy services and medicines optimisation metrics with providers across the country. The report for 2024 isn't available currently as data collection and submission has only recently taken place therefore no update from last year's report.

7. Workforce

At NLaG, throughout 2023/24 the pharmacy service continued to be impacted by significant pharmacist vacancies however is starting to see the benefit of several recruitment initiatives. All vacant Band 6 pharmacist posts have now been offered with some pharmacists now in post and other posts offered to current trainees who are due to start between July and September subject to professional registration. Pharmacist recruitment for foundation pharmacists at HUTH has proved more challenging than in previous years and due to turnover and promotion of current post holders we are still recruiting to these posts.

We have committed to having a stand at the Clinical Pharmacy Congress North (held in Manchester) again in 2024 where over 1,200 pharmacy professionals are expected to attend so we can actively showcase the Group and promote the area.

In the NHS Benchmarking Network's Pharmacy and Medicines Optimisation report the established pharmacy staff posts per 100 beds at NLaG was in the bottom quartile across each staff group and HUTH was below median for pharmacists and pharmacy technicians and above for pharmacy support workers.

Pharmacists	median 8.1 vs HUTH 7, NLaG 5.3
Pharmacy Technicians	median 7.4 vs HUTH 6.6, NLaG 5.3
Pharmacy Support Worker	median 4.5 vs HUTH 5.6, NLaG 3.1

Whilst NLaG benefit from some efficiencies such as our stores robot and closed loop dispensing, further work is required to ensure the pharmacy service is right sized for the organisation.

The pharmacy profession continues to innovate and transform to help meet the challenges the NHS faces. In January 2021, the General Pharmaceutical Council (GPhC) published the revised Standards for the Initial Education and Training of Pharmacists. These new learning outcomes enable pharmacists to be independent prescribers at the point of registration from 2026. In order to respond to this we need to increase the number of undergraduate placements we can offer so undergraduate trainees have the opportunity to develop the necessary skills and confidence to provide clinical services expected by patients and the NHS. We also need to increase the number Designated Prescribing Practitioners to support Foundation Trainee Pharmacists across our region to achieve professional registration.

Alongside this we need to invest in the training of our Pharmacy Technicians who will need to take on additional clinical roles, as well as training our Pharmacy Support Workers so they can provide ward based technical support to improve the way medicines are managed. This transformation of the pharmacy workforce can release nursing and clinician time by improving the multidisciplinary skill mix for patient care and support the ethos that each profession should be focussed on the aspects of care only they can deliver.

8. Summary

The Annual Medicines Optimisation report provides an account of medicines management and optimisation activities undertaken over the last year. It is intended to update the Board on the Trust's medicines optimisation arrangements, outlining progress made in year, as well as the key areas of concern and plans going forward for the next year.

Key achievements:

- Recruitment within the pharmacy team on the NLaG site. On trajectory for majority of posts being filled by October 2024
- Achieved the Commissioning for Quality and Innovation framework linked to the implementation of the discharge medicines service to improve patient outcomes by collaboratively communicating with community pharmacies about medicines when patients transfer to a different care setting for a second year
- Establishment of the first consultant pharmacist posts at HUTH for Haematology and Antimicrobial Stewardship and Infectious Diseases

Key areas of concern:

- Medicines Reconciliation within 24 hours of admission across the group remain below expected levels, impacted by challenge arising from pharmacy vacancies
- Antimicrobial usage at NLaG

- Lorenzo ePMA concerns around product alert notices, reporting functionality and integration with other systems at HUTH

Key plans for next year

- Review the underlying Key Performance Indicators in this report and standardise across the group
- Medicines Management Nursing team to lead on improving Safe and Secure storage of medicines KPI using Quality Improvement methodology at NLaG
- Support work to progress a single system Area Prescribing Committee and single formulary approach to tackle inequality in the current system
- Share learning on successful antimicrobial strategies to ensure appropriate prescribing and use at NLaG
- Prepare for changes to the Foundation Trainee Pharmacist programme by increasing the number of pharmacists eligible to become Pharmacist Designated Prescribing Practitioners

Recommendation to the Board

This report is presented for the Board's approval.

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)158

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 8th August
Director Lead	Gill Ponder and Helen Wright, Non-Executive Directors (Chairs)
Contact Officer / Author	Gill Ponder and Helen Wright, Non-Executive Directors (Chairs)
Title of Report	Minutes of the Performance, Estates and Finance Committees-in-Common meetings held in May and June 2024
Executive Summary	The minutes attached are the formal account of the meetings of the Performance, Estates and Finance Committees-in-Common from 29 May and 26 June 2024. The minutes include any actions and resolutions made
Background Information and/or Supporting Document(s) (if applicable)	Performance, Estates and Finance Committees-in-Common Terms of Reference for HUTH and NLaG
Prior Approval Process	Approval at the April and May Performance, Estates and Finance Committees-in-Common meetings
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

PERFORMANCE ESTATES AND FINANCE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Wednesday, 29 May 2024 at 09:00 to 12:30 hours in the Nightingale Room, Education Centre, Scunthorpe General Hospital

For the purpose of transacting the business set out below:

Present:

Core Members:

Gill Ponder	Non-Executive Director (NLaG) - Chair
Julie Beilby	Associate Non-Executive Director (NLaG)
Lee Bond	Group Chief Financial Officer
Jane Hawkard	Non-Executive Director (HUTH)
Mike Robson	Non-Executive Director (HUTH)
Shaun Stacey	Group Chief Delivery Officer
Dr Kate Wood	Group Chief Medical Officer

In Attendance:

Leah Coneyworth	Head of Quality Compliance and Improvement (HUTH)
Adam Creeggan	Group Director of Performance
Andy Haywood	Group Digital Information Officer
Craig Hodgson	Group Deputy Director of Commercial and Facilities Services
Alison Hurley	Deputy Director of Assurance (NLaG)
Sean Lyons	Chair (NLaG)
Ivan McConnell	Group Chief Strategy & Partnerships Officer
David Sharif	Group Director of Assurance
Sally-Ann Campbell	Personal Assistant (Minutes)

Observers

Stuart Hall	Vice-Chair (HUTH)
Ian Reekie	Lead Governor (NLaG)

KEY
HUTH - Hull University Teaching Hospitals NHS Trust
NLaG – Northern Lincolnshire & Goole NHS Foundation Trust

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The Performance, Estates and Finance (PEF) Committees-in-Common (CiC) Chair, Gill Ponder, welcomed those present to the meeting. No apologies had been received.

1.2 **Declarations of Interest**

No declarations of interests were received in respect of any of the agenda items.

1.3 **To approve the minutes of the meeting held on 24 April 2024**

The minutes of the meeting held on the 24 April 2024 were accepted as a true and accurate record.

1.4 **Matters Arising**

No items were raised.

1.5 **Committees-in-Common Action Tracker**

The following updates to the Action Tracker were noted:

3.1 (Group) – Board Assurance Framework (BAF) – 24 April 2024 – as the digital plan delivery update was on the agenda under item 4.5, this action was closed.

3.2 (Group) – Risk Register Report – 24 April 2024 – this was discussed at the April meeting of the Audit, Risk and Governance Committee. This action was closed.

4.3 (Group) – Group Integrated Performance Report (IPR) – 24 April 2024 – addressed under agenda item 5.6 and the action was closed.

4.3 (Group) – Group IPR – 24 April 2024 – the planned meeting had not taken place to discuss a hospital discharge scheme due to Shaun Stacey leaving the organisation. The meeting would take place once his successor was in place. This action was deferred until July.

4.3 (Group) – Group IPR – 24 April 2024 – a report on theatre utilisation figures was on the agenda under item 5.9 and this action was closed.

4.4 (NLaG) - Estates and Facilities – General Update – 24 April 2024 – the work on the water tanks at Scunthorpe General Hospital (SGH) had been completed and the improvement notice closed. However, outstanding work on the water pipes in the Emergency Department (ED) remained and it was noted that the Health and Safety Executive (HSE) could visit unannounced and issue a new improvement notice until all pipes had been replaced. The Chair asked that all improvement/enforcement notices should be brought to the attention of the PEF CiC by including them in the monthly Estates and Facilities report to the Committee. This action was closed.

2. MATTERS REFERRED

2.1 **Matters referred by the Trust Board(s) or other Board Committees**

Gill Ponder reported that no items had been referred for consideration at present to the PEF CiC.

2.2 Digital Plan Delivery – Data Accuracy & Access to Reporting

This was addressed under agenda item 4.5.

3. RISK & ASSURANCE

3.1 Board Assurance Framework (BAF)

The report was taken as read and David Sharif provided an overview of the BAF elements which the PEF CiC had oversight of. This included a progress update regarding the harmonisation and rationalisation of the BAFs for HUTH/ NLaG Finance, Estates and Performance Risks to reflect the Group position. Key points were then highlighted.

The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors was noted.

A further risk was noted in relation to either the Trust or the Humber and North Yorkshire Integrated Care System (ICS) would fail to achieve their financial objectives and responsibilities.

A detailed discussion ensued around the likelihood and consequence elements of the risk scores and the impacts of changes to both. This was particularly relevant for the Group performance risk and the estates, infrastructure and equipment risk. It was agreed that definitions and examples would be helpful to include in the BAF, especially for likelihood, consequence and assurances. Gill Ponder offered her support outside of the meeting if this was required.

David Sharif advised the BAF was very much a work in progress and would be refreshed to provide an overview from a Group perspective in it's next iteration.

Gill Ponder queried which committee had oversight of the Business Continuity Plan and David Sharif agreed to seek clarification and report back to the Committee.

Sean Lyons informed the Committees that he had found this update very useful and felt that it captured both the positive, negative and planned aspects of the BAF.

***ACTIONS**:*

- *The BAF to be reviewed and all risks re-assessed. A report to be produced with an overview from the Group perspective*
- *David Sharif to clarify which Committee has oversight of the Business Continuity Plan.*

3.2 Risk Register Report

David Sharif provided a verbal update on the Risk Register and informed the Committee that there were 110 high level risks. Rob Chidlow, Interim Group

Director of Quality Governance, was undertaking a full review of the Risk Register and would present a paper at the Cabinet Risk and Assurance Group the following day. It would then be submitted to the Executive Cabinet meeting on 1 July 2024 for review of the high-level risks.

David Sharif confirmed that the Risk Register Report would be revised and aligned with the BAF and he planned to present the revised report to the August PEF CiC.

Gill Ponder reminded members that the PEF CiC had referred the lack of oversight of the Risk Register to the ARG CiC for consideration of any gaps in controls and whether they had been sufficiently mitigated.

In response to a query from Stuart Hall, David Sharif confirmed that issues versus risks would be clarified too.

***ACTION**: The Risk Register Report to be reviewed, aligned with the BAF and presented to the August PEF CiC meeting*

3.3 **Review of Relevant External & Internal Audit Report(s) & Recommendation(s)**

There were no external or internal audit reports & recommendations to note.

3.4 **Review of Relevant External Report(s), Recommendation(s) & Assurances(s)**

There were no external reports, recommendations or assurances to note.

Leah Coneyworth joined the meeting at 9.35am.

3.4.1 **Care Quality Commission (CQC) Actions Report – Group**

Gill Ponder welcomed Leah Coneyworth to the meeting.

Leah Coneyworth provided an overview of the HUTH CQC actions report and informed the Committees that there had been no real change in the position at HUTH since the last meeting in relation to the ED and the Same Day Emergency Care (SDEC). Out of a total of 43 actions, 42 had been completed. Of the 27 actions in the regulation action plan which included 15 'Must Do's', 19 had been completed, a further six actions have been implemented with ongoing monitoring and two actions are reported as overdue.

The national CQC Maternity Team inspected HUTH Maternity services in March 2023 and, as a result, a Section 31 notice had been issued following a revisit in April 2023. Significant improvements had since been evidenced but this remained open until data collection and reporting issues are resolved with the recent implementation of the BadgerNet system.

Across the five action plans there are currently three open actions linked to the PEF CiC from HUTH.

Mike Robson queried whether the Ground Floor Project in ED and the opening of the Urgent Treatment Centre (UTC) had relieved pressure in the ED. Shaun Stacey informed the Committees that the anticipated reduction in pressure on ED had not, as yet, materialised following the opening of the UTC. An overview of the issues was provided and it was confirmed that liaison with the City Health Care Partnership (CHCP) who operate the UTC was underway and an update on performance figures should be available by mid-July. Members were informed that changes have been made in how the Ground Floor operates but there are multiple factors at play which influence what can be achieved. For example, one of the No Criteria to Reside Wards (NCTR) would need to be closed, greater engagement of the Trust with local authorities and other interested parties is required to drive the service forward and a change in culture needs to be adopted. Ivan McConnell confirmed that Place Directors are integral to making these changes across multiple agencies.

Gill Ponder thanked Leah Coneyworth for her report and confirmed full assurance was felt that all items had been addressed.

Leah Coneyworth left the meeting at 9.45am.

Due to technical issues Jennifer Granger had been unable to join the meeting so Kate Wood presented the NLaG CQC report which was taken as read with any questions invited. Gill Ponder noted the good progress to amalgamate the two Trust reports which had been simplified and were very helpful.

Lee Bond raised concerns regarding the five items listed in Appendix 1 and was not fully assured of the significant assurance stated. Kate Wood informed the Committees that since the CQC visit to NLaG in 2022 significant progress had been made and confirmed the financial balance was based on the 2023/24 status. Lee Bond re-iterated his concerns and noted the gargantuan financial future issues to be addressed.

Sean Lyons commented on the need for correct and current classifications, and consistency in colour coding was now required with some urgency.

REVIEW ASSURED, ESCALATE OR ADDITIONAL INFORMATION REQUESTED?

Gill Ponder noted the following:

- that all open external notices, such as those received by Estates, be brought to the attention of the Committees
- the Risk Register Report was still not been available
- the revision of the BAF remained a work in progress but the Committees were assured by what had been achieved so far.

4. COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 Financial Report – Month 1

Lee Bond presented the report and highlighted the following points. The Group reported an in-month deficit for month 1 of £6.2 million which was £2.0 million

adverse of plan. The Group had delivered £3.2 million against the challenging Cost Improvement Programme (CIP) savings against a year to date (YTD) target of £4.6 million being £1.5 million below plan and the Group Capital spend was £2.3 million below plan at the end of Month 1. There remained £10.5m of unidentified CIP savings.

The spend on temporary staffing had reduced particularly with regards to agency and bank spend at NLaG. This was largely due to an additional step being introduced into the approval process. Medical Staffing however remained a difficult area to reduce spend at present. Work was being undertaken with the Care Groups to address the overspend in corporate areas.

Mike Robson acknowledged that there had been a good start to the financial year by NLaG but that HUTH were not performing as well. The NLaG reduction in agency spend was applauded and the need to reduce the number of beds at HUTH to bring their performance back in line with targets was acknowledged.

The Performance Meetings with the Care Groups were due to take place the following day but the Finance Support for each group was still to be agreed.

Following a discussion about cash flow assumptions, and delivery of CIP and Elective Recovery Funds (ERF), Lee Bond confirmed that the Month 2 Finance Report would provide greater detail as more data would be available to populate the report due to technical issues in month 1. It was also noted that the Group may need to access financial support for cash in month 7. That position would deteriorate if planned CIP savings and productivity improvements were not delivered.

Clinical staffing requirements at the Queen's Centre in Hull were discussed and it was confirmed that the Chief Nurse Establishment Review was due at the upcoming Trust Boards-in-Common meeting which would cover this issue.

Julie Beilby queried whether procurement schemes included CIP considerations for recurrent savings especially across the ICS and Lee Bond confirmed that this would be Group or ICS level as appropriate.

Lee Bond supported the need to reduce follow up appointments as only 75% of costs were paid in response to queries from Stuart Hall and Gill Ponder.

Gill Ponder thanked Lee for the report and updates provided.

REVIEW ASSURED, ESCALATE OR ADDITIONAL INFORMATION REQUESTED?

It was agreed that the following items would be included in the highlight report to the Board:

Month 1 achievement against very high risk financial plan.
£10.5m unidentified CIP.
Anticipated need for cash support.
Reduction in spend on temporary staffing at NLAG.

4.2 **Group Integrated Performance Report (IPR)**

Shaun Stacey introduced the report and highlighted that the referral to treatment (RTT) list had increased but the 65-week list had decreased and stabilised. Adam Creeggan informed members that there were currently an additional 500 patients per week which had resulted in a huge strain being placed on administrative support. This had resulted in delays with the care pathways and data being recorded in Lorenzo. Additional support had been provided to help clear the backlog which would take approximately three weeks to resolve.

An issue remained with the number of operations being cancelled for non-clinical reasons and late starts as referred to by Lee Bond. Theatre utilisation required improvement with an associated cultural change to achieve better results. Shaunn Stacey provided an overview and advised that various initiatives were being considered which included moving to a seven-day operating model.

Both Trusts had improved their 62-day Cancer performance. HUTH's Faster Diagnosis Standard had also improved, but NLaG's had deteriorated. NLaG were now receiving Tier 1 support from NHSE on Cancer performance. However, it was noted that a number of measures were very close to target levels, so the Committee discussed the additional efforts that could be made to get performance in those areas over the target levels.

Footfall through ED had reduced overall since the opening of the UTC but further work was still required. NLaG had shown an improvement for the second month in a row but it was not considered to be sustainable. HUTH were evidencing some stability with the four-hour target and a slight improvement in ambulance handovers was evident on the south bank. However, neither Trust had achieved the 76% target. Adam Creeggan informed the Committees of some data discrepancies due to differences with Group data and ambulance service data which was being reviewed.

Whilst the benefits of the SDEC and IAAU models were being seen, frailty remained a concern, as too many elderly patients were being admitted after long waits in ED. The Committee also expressed concern about the ability to embed and sustain the improvements shown during Multi-Agency Discharge Events (MADE) events.

4.2.1 **Deep Dive – Diagnostics**

Adam Creeggan introduced the report which provided detailed analysis of key diagnostic modalities in respect of activity levels and performance against the six weeks' waiting time threshold.

There were 13,000 pathways live at HUTH and 10,000 live at NLaG which had shown an improvement and meant that the Trust was in the Middle Quartile. There were issues at HUTH with the Dual-energy X-ray Absorptiometry (Dexa) which was currently the worst in the country and it was acknowledged that investment was required to provide additional staff and a business case had

been submitted to address this. Lee Bond confirmed that the Dexa scanner was not fully utilised and noted the increase in imaging activity with the use of the mobile units.

Shaun Stacey referred to the ongoing maintenance issues on the Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) scanners which affected productivity due to down time and a discussion ensued about possibilities to address the issues and improve productivity. Lee Bond agreed and explained some of the issues were due to the age of the equipment.

Other modalities were discussed and it was noted that there were plans in place to address the significant variations in performance between the Trusts.

Sean Lyons thanked Adam Creeggan for the well-structured and informative report. Gill Ponder concurred and invited questions.

Sean Lyons queried whether the move to the Care Group structure had impacted on diagnostics. Adam Creeggan confirmed the move to the Care Group structure had been the best way forward and was definitely more effective because it facilitated the adoption of best practice and mutual aid within the Group.

Gill Ponder noted the very useful and effective report with granular detail which was very helpful. Assurance was noted that all actions were being undertaken where possible.

REVIEW ASSURED, ESCALATE OR ADDITIONAL INFORMATION REQUESTED?

Plans to recover the backlog of patient outcomes awaiting input to Lorenzo.
The ability to embed and sustain improvements shown during MADE events.
NLaG receiving Tier 1 support to improve Cancer performance.
Plans to improve theatre utilisation and productivity.
Craig Hodgson joined the meeting at 11.05am.

4.3 **Estates and Facilities – General Update**

The report was taken as read and Craig Hodgson highlighted the following points. The report provided compliance and information updates in regard to managing the estate together with current progress of schemes at HUTH and NLaG. It also provided an update on the Capital Development Programmes.

A loss in income from the retail catering units on the North bank was noted together with a review being undertaken on the cleaning contract operated by OCS which was due to expire in May 2025. The TV services contract also had also been terminated, but would be operational during the 6 months' notice period. The Committee suggested a strategic review of catering and retail arrangements.

The decrease in demand for accommodation at NLaG was discussed, which was due to overseas nurses not being recruited this year so contracts for leased properties would be terminated where possible. However, 46 additional

accommodation units were being sought in Scunthorpe, due to an expected future increase in the number of Junior Doctors.

Gill Ponder thanked Craig Hodgson for presenting the report.

4.3.1 **Health and Safety Policy Statement**

Craig Hodgson provided an overview of the Health and Safety Policy statement and confirmed it was based on the existing NLaG policy statement.

Jane Hawkard queried whether there was a best practice standard for this and whether it had been used. A discussion was held about what needed to be included in the statement and Gill Ponder suggested the inclusion of the provision of supervision. Craig Hodgson confirmed the statement was in line with best practice.

The Committee approved the policy with the addition on page 3, bullet point 1, "Introducing, developing and maintaining safe systems of work ……improving existing systems to further raise standards and include supervision."

Craig Hodgson left the meeting at 11.45am

4.4 **Contract Approvals**

4.4.1 **Supply of Radiopharmaceuticals and Associated Consumables**

The Committee approved the 4-year contract but noted that the contract had already expired and requested that such contracts be brought to the Committee in a more timely fashion in future.

Andy Haywood joined the meeting at 11.41am

REVIEW ASSURED, ESCALATE OR ADDITIONAL INFORMATION REQUESTED?

The Health and Safety Policy Statement and the contract for the Supply of Radiopharmaceuticals and Associated Consumables were approved. The loss of income from the catering and retail outlets was noted together with a suggestion for a strategic review of retail and catering arrangements.

4.5 **Digital Plan Delivery Report – Data Accuracy & Access to Reporting**

Adam Creeggan presented the report which aimed to provide assurance to the Committees on data accuracy and access to reporting for the Group. No data had been lost or corrupted during the transition to Lorenzo and access to reports remained, but the method of accessing them had changed. Further training and support had been provided to staff to enable them to find the data and reports they had reported difficulty in accessing.

The Group Chief Digital Information Officer, Andy Haywood, confirmed that the digital infrastructure is still largely individual for HUTH and NLaG, rather than a joint Humber Health Partnership for the Group infrastructure, but a new

infrastructure was a work in progress. A common principle was that all staff should be able to access the reports required. Any issues raised were to be reported to the IT service desk for support. A Digital Strategy was planned for October/November 2024 which would address progression to a single digital infrastructure and tactical plans were being developed ahead of a main strategy for NHS Mail, 0365 and network resilience.

Gill Ponder confirmed that the Committee were assured by the Digital report and updates provided.

Andy Haywood left the meeting at 12.02pm.

4.6 **Emerging Issues**

None had been identified.

REVIEW ASSURED, ESCALATE OR ADDITIONAL INFORMATION REQUESTED?

Assurance had been received with the Digital report and updates provided.

5. ITEMS FOR INFORMATION

5.1 **Work Plan for PEF CiC**

The workplan was received by the Committees. David Sharif informed the Committee that workplans for the CiCs were currently under review.

It was noted that the topics for the operational deep dives needed to be added to the plan.

5.2 **Consolidated North Bank Site Report**

Shaun Stacey informed the Committees these meetings had not yet taken place and reports would be available for the next meeting of the PEF CiC.

5.3 **Consolidated South Bank Site Report**

As above.

5.4 **Planned Care Board Meeting Minutes**

Shaun Stacey informed the Committees that the minutes had not been ratified and would therefore be brought to the next meeting of the PEF CiC.

5.5 **Unplanned Care Board Meeting Minutes**

The minutes of the meeting held on 30th April 2024 had been circulated for information.

5.6 **Get It Right First Time (GIRFT) Report**

The initial report and an update report had been circulated for information.

5.7 **Review of March 2024 Multi-Agency Discharge Event (MADE) – North Bank**

The report had been circulated for information.

5.8 **Review of March 2024 Multi-Agency Discharge Event (MADE) – South Bank**

The report had been circulated for information.

5.9 **Theatre Utilisation Report**

The report had been circulated for information.

REVIEW ASSURED, ESCALATE OR ADDITIONAL INFORMATION REQUESTED?

The Committees were assured of the success of the MADE events and the lessons learned.

6. ANY OTHER URGENT BUSINESS

Gill Ponder expressed her thanks on behalf of the Committees, to Shaun Stacey, Group Chief Delivery Officer and Mike Robson, Non-Executive Director (HUTH) and Co-Chair of the PEF CIC Committee, who were leaving the Group shortly for all their hard work, the significant impact they had made and support they had provided. Sean Lyons concurred and added that they would be a loss to the Group and very much missed and expressed thanks on behalf of Board colleagues.

7. MATTERS TO BE REFERRED BY THE COMMITTEES-IN-COMMON

7.1 **Matters to be Referred to other Board Committees**

There were no matters for referral to any of the other Board Committees.

7.2 **Matters for Escalation to the Trust Boards**

- Items for escalation to the Board were captured in the summaries after each section of the agenda above.

8. DATE AND TIME OF THE NEXT MEETING

8.1 **Date and time of the next PEF CiC meeting:**

Wednesday, 26th June 2024 at 09:00 hours, Nightingale Room, Education Centre, Scunthorpe General Hospital

Gill Ponder thanked everyone for their attendance and contributions. The meeting closed at 12:16 hours.

Cumulative Record of Attendance at the PEF CiC 2024/2025

Name	Title	2024											
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
CORE MEMBERS													
Gill Ponder	Chair / Non-Executive Director (NED – NLaG)	Y	Y	Y	Y	Y							
Mike Robson	Chair / Non-Executive Director (NED - HUTH)	Y	Y	Y	Y	Y							
Lee Bond	Group Chief Financial Officer	Y	D	Y	Y	Y							
Jane Hawkard	NED (HUTH)	Y	Y	Y	Y	Y							
Simon Parkes	NED (NLaG)	Y	Y	Y	Y	N							
Shaun Stacey	Group Chief Delivery Officer	Y	Y	Y	Y	Y							
Dr Kate Wood	Group Chief Medical Officer	D	Y	D	Y	Y							
REQUIRED ATTENDEES													
VACANT	Group Director of Estates	D	D	D	D	D							
Andy Haywood	Group Digital Information Officer	N	N	Y	N	Y							
David Sharif	Group Director of Assurance or deputy	D	D	Y	Y	Y							
Alison Drury	Deputy Director of Finance (HUTH)	Y	N	N	N	Y							
Brian Shipley	Deputy Director of Finance (NLaG)	Y	Y	Y	N	N							
Stephen Evans	Operational Director of Finance (HUTH)	Y	Y	N	N	N							
Ian Reekie	Governor Observer (NLaG)	Y	Y	Y	Y	Y							

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

PERFORMANCE ESTATES AND FINANCE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Wednesday, 26 June 2024 at 09:00 to 12:30 hours in the Nightingale Room, Education Centre, Scunthorpe General Hospital

For the purpose of transacting the business set out below:

Present:

Core Members:

Gill Ponder	Non-Executive Director (NLaG) – Chair
Lee Bond	Group Chief Financial Officer
Simon Parkes	Non-Executive Director (NLaG)
Dr Kate Wood	Group Chief Medical Officer
Helen Wright	Non-Executive Director (HUTH)
Paul Bytheway	Group Chief Delivery Officer
Ivan McConnell	Group Chief Strategy & Partnerships Officer (HUTH)

In Attendance:

Jonathan Lofthouse	Group Chief Executive
Adam Creeggan	Group Director of Performance
Jennifer Granger	Head of Compliance & Assurance (NLaG) (For item 3.4.1)
David Sharif	Group Director of Assurance
Craig Hodgson	Interim Group Deputy Director of Estates, Compliance and Information (NLaG) (For item 4.3)
Rebecca Thompson	Deputy Director of Assurance (HUTH)
Sally-Ann Campbell	Personal Assistant (Minutes)
Lauren Rowbottom	Personal Assistant (Minutes)
Jackie France	Operations Director, Patient Services (For item 4.2.1)
Brian Shipley	Deputy Director of Finance (NLaG)
Linda Jackson	Vice-Chair (NLaG)
Julie Beilby	Associate Non-Executive Director (NLaG)

Observers

Ian Reekie	Lead Governor (NLaG)

KEY

HUTH - Hull University Teaching Hospitals NHS Trust
NLaG – Northern Lincolnshire & Goole NHS Foundation Trust

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The Performance, Estates and Finance (PEF) Committees-in-Common (CiC) Chair, Gill Ponder, welcomed those present to the meeting. Apologies for absence were noted for Jane Hawkard, Non-Executive Director (HUTH) and Alex Best, Deputy Director of Capital Services.

1.2 Declarations of Interest

No declarations of interests were received in respect of any of the agenda items.

1.3 To approve the minutes of the meeting held on 29 May 2024

The minutes of the meeting held on the 29 May 2024 were accepted as a true and accurate record.

1.4 Matters Arising

No items were raised.

1.5 Committees-in-Common Action Tracker

The following updates to the Action Tracker were noted:

4.3.1 – Length of Stay and Beds deep dive
As a deep dive into Length of Stay and Bed Numbers was planned on the Committees' Workplan for August, it was agreed to take this action in conjunction with that.

4.5.1 – Contract Approvals - Routine Radiology
Lee Bond updated that this was regarding a contract that was due to expire at the end of the first quarter and there was a query whether the contract would be further extended. It was agreed to carry the action forward to July.

3.1 – Board Assurance Framework (BAF)
Updated Terms of Reference (TOR) would be formally approved at a future board meeting. The Business Continuity risk will be received by the Audit, Risk and Governance Committee. It was agreed for the action to be closed.

2. MATTERS REFERRED

2.1 Matters referred by the Trust Board(s) or other Board Committees

Gill Ponder reported that no items had been referred for consideration at present to the PEF CiC.

3. RISK & ASSURANCE

3.1 Board Assurance Framework (BAF)

The report was taken as read and David Sharif provided an overview of the report which contained details of the corporate risks. He advised that there had not been any changes to the risk ratings. He noted that there had been a conversation at Cabinet regarding the finance risk and whether this should be a risk rating of 25. Lee Bond raised that the score was discussed at the Risk and Assurance Committee where it was broken down to look into whether the risk score was accurate against the rules, but agreed that when placed against some of the Quality and Safety risks they may take precedence. The NEDs noted that risks were due to be reviewed further at the Board Development session in July 2024.

Helen Wright added that the likelihood of 5 for the finance risk required review given the amount of effort involved in rolling out the finance plans for the year including significant cost improvement plans and initiatives. It is not appropriate in Quarter 1 to conclude that these will not be delivered.

Julie Beilby raised that the business continuity risk was reassuringly low, but did raise concerns that the risk did not include anything regarding complete Information Technology outage. Paul Bytheway reassured the CIC that he would investigate this with Adam Creegan and the EPR team, ensuring action plans are robust as well as reviewing the Business Continuity Plan. This will be reviewed by the Audit, Risk & Governance Committee.

3.2 Risk Register Report (HUTH & NLaG)

David Sharif provided a verbal update on the Risk Register progress and advised that the report was still work in progress but would be presented to the July 2024 CIC.

Action: David Sharif to provide an up to date risk register report for the next PEF.

Helen Wright raised that she was still trying to understand the process around risk identification and wondered if there were risk champions in the Group. David explained there were but there may be some difference in roles across the sites and this would form part of the ongoing work to refresh the risk management strategy.

Jennifer Granger joined the meeting at 09.20am.

3.3 Review of Relevant External & Internal Audit Report(s) & Recommendation(s)

There were no external or internal audit reports & recommendations to note.

3.4 Review of Relevant External Report(s), Recommendation(s) & Assurances(s)

There were no external reports, recommendations or assurances to note.

3.4.1 CQC Actions Report – Group

NLAG Update:
Jennifer Granger gave a brief overview of the report. She informed the Committees that work was underway to align the North and South reports and they would be using the same terminology and report template. She added that since the report was submitted some of the timescales of the actions had been amended, 1 had been closed and 5 remained open; 2 of the open actions were green and 3 were amber. Jennifer updated the CIC on the amber actions which related to end of life, cancer waiting times and overdue appointments.

Paul Bytheway asked about the cancer RAG rating and Jennifer explained that she was working with Julia Mizon, Ashy Shanker and Neil Rogers, who had given her the information regarding the trajectories.

Dr Kate Wood updated that there was going to be a performance workshop with Adam Creegan's team and all the Care Groups to ensure everyone is confident and well sighted with their data capture and presentation.

Helen Wright raised that there appeared to be more actions completed on the 'should do' list rather than the 'must do' list and asked if this was because they were more complex. Jennifer Granger advised that this was the case.

Gill Ponder was pleased to see the amber actions down from 5 to 3, but asked when the remaining 3 would be green. Jennifer explained that two of the actions were expected to be in March 2025 (Cancer Waiting Times and Overdue Appointments). The end of life action had a timescale of the end of June 2024, but this would be reviewed at the Quality Improvement workshop in July 2024.

Simon Parkes raised concerns around the deadlines of the actions and what the consequences were of pushing the completion dates back by a year. Kate Wood advised that there was a national issue regarding Outpatient and Cancer performance and that many Trusts were struggling, therefore it was normal for plans to change.

The HUTH report was received by the Committee.

Jennifer Granger left the meeting at 09.32am.

The Committees agreed that they had nothing to escalate to the Board from the topics covered up to this point in the meeting and agreed that they had received reasonable assurance.

4. COMMITTEE SPECIFIC BUSINESS ITEMS

<u>Joint Business Items</u>

4.1 **Financial Report – Month 2**

Brain Shipley updated the CIC and advised that the year to date Group position was £12.3 million deficit, which was £3.9 million adverse to plan. HUTH were £3.4m behind plan and NLaG were £0.6m behind plan. The underlying position was £92.5 million deficit, which showed no movement from May.

Brian Shipley advised that the cash position would need to be managed and would continue to be a key focus in months 3 and 4. There would be further funding to help the planned deficit move to a break even position. The success of the Cost Improvement Plan would determine whether external cash support would be required in year.

Brian raised that the Elective Recovery performance was slightly behind plan due to a number of uncashed clinics.

Brian explained that they had reduced the temporary nursing agency bill, particularly on the NLaG sites. An average £1m spend last year had now dropped to £215k. Linda Jackson asked about the Urgent and Emergency Care(UEC) medic agency spend and whether there was a plan to target this area. Brian Shipley explained that it was about the nursing directorates having the control in terms of allocation and new protocols have been put in place for escalation and they were keeping an eye on the vacancy position. Linda Jackson asked whether the UEC required any support with recruitment and Brian Shipley advised that UEC was a difficult area to recruit into, but there were 7 Doctors due to start.

Simon Parkes expressed how great it was to see the number of bank and agency numbers falling and wondered when the Group would see the impact of this in the performance figures. Jonathan Lofthouse explained that there was now traction on the removal of all patients waiting 78 weeks for elective treatment and this would be achieved by the end of June 2024. He added that over the next 3 months the emergency care plan would start to show improvements, too.

Jonathan Lofthouse gave an update on the MARS Scheme. A meeting was to take place to review the MARS applications on the 26 June 2024. It was noted that not all of the applications would be approved as some posts were key, but the scheme would help Care Groups re-engineer their services and fastrack improvement plans.

Lee Bond updated that UEC was still consuming a lot of resources, particularly medical staffing. He added that in the upcoming reports he would be adding a forecast for throughout the year and this would include a section on risk. The risk section would cover MARS, band 2-3 nursing and industrial action so everyone is informed. He noted that as we got closer to delivering the CIP, this would have an impact on the cash position and he was hopeful that going into Q4 the Group would not require any cash support. He was also optimistic regarding the activity side.

Helen Wright asked about progress on the cost saving initiatives that were highlighted at the board meeting and when the Finance team could update the committees on status. Ivan McConnell informed the Committees that the full plans with trajectories would be agreed by the end of July 2024 and then would be brought to PEF.

Action: Ivan McConnell to provide an update on cost improvement initiatives at August PEF meeting.

Helen Wright queried if overtime levels were expected to rise by reducing agency staffing and would this create an issue. Lee Bond explained that there would be a reliance on Bank staff but they were paid at normal, rather than premium, rates. Brian Shipley advised that this detail would be added into next month's report.

Helen Wright wondered if there was anything that could be done internally to help manage cash through working capital optimisation. Brian Shipley explained that working capital levels were steady but creditors were being actively managed to ensure no early payments.

Gill Ponder asked whether the team are doing anything specific to increase activity beyond plan. Lee Bond explained there was a slight issue around overtime payments with Doctors, but there was work ongoing to increase activity with elective patients. He added that initiatives like encouraging clinical staff to work at agreed internal rates and engaging with the private sector were underway.

Adam Creegan added that they were finalising a paper that showed improvement schemes relating to elective recovery and the impact of the diagnostic improvements, which was an enabler to elective improvements. The report would be presented to the Cabinet and would then come to PEF.

The Committee agreed that the improving cash position should be highlighted to the board and that under-delivery of CIP should be escalated.

Reasonable assurance was agreed as a result of the plans and commitments in progress.

4.2 **Group Integrated Performance Report**

The report was taken as read and Adam Creegan explained that compliance with UEC was difficult to track this year due to NHSE adding a requirement to manage performance against acute footprint of Urgent Treatment activity, which included Goole, Bransholme and East Riding Community Hospital (ERCH). HUTH was showing 61% performance against the plan with NLaG at 70.5%. HRI was not delivering at a planned level and the footfall for the Urgent Treatment Centre (UTC) was lower than planned following the move from Storey Street, which was being reviewed with City Health Care Partnership (CHCP). Bransholme and ERCH were at 70% compliance.

Adam Creeggan gave an update on the time it took to see a clinician in the Emergency Department and that ED had seen less non-admitted breaches as a result of the integrated pathway. Detailed monitoring was being managed in the UEC group and improvement programmes were starting to show some improvements. He added that the underlying governance changes are simplifying the problems and generating some positive changes to address them.

Adam Creeggan also raised some positives from the IPR such as the commitment to clear 78 week waits by June which was achieved and the trajectory for 65 weeks was also on track. This had created some growth in the RTT Waiting Lists which was noted as being an underlying risk. Further work is being planned to increase day cases and reduce Outpatient follow ups where possible to create new appointments to reduce the overall wait time.

Adam Creeggan updated the Committees-In-Common that diagnostic delivery remained ahead of trajectory, with the intention of driving this further. There had been good compliance in imaging modalities and plans were being created in every modality to get to a 22 day delivery across all modalities.

Cancer 62 day compliance was being challenged by focusing on the Faster Diagnosis Standard, especially at NLag where performance was lower than at HUTH. Plans were in place for every modality, including aiming for 7 days to diagnosis and treatment plans being in place by day 38 to hit the overall 62 day standard. This had led to improvements at both HUTH and NLaG, but there was more to be done.

Paul Bytheway added to this that Elective Care was moving in the right direction, but there were still some challenges. He expressed that Urgent Care needed focus and needed help with the belief in UEC pathway. This was all about hearts and minds and feeling like a difference can be made. This will be supported through 6-week transactional plans. Paul Bytheway had met with Stephen Eames, the Chief Executive at the ICB, to have a supportive conversation about what could be done collectively to help make a difference. Following this, a piece of work has been generated to focus on the key areas on each individual site.

Simon Parkes praised the IPR, mentioning it was helpful and clear to see what was happening, but felt there seemed to be less detail about certain actions and what is expected to help deliver those to improve performance. Adam Creeggan explained that as the IPR evolved, trajectories and metrics would be added.

Lee Bond discussed the data quality issues within theatres from the report and queried whether this would be rectified. Adam Creeggan explained the Lorenzo deployment had generated some issues and continued to be complex. A revised methodology was expected by July. Lee Bond queried the number of diagnostics total compared to the activity levels and Adam Creeggan assured him that the total numbers would not add up as it included modalities outside of the named 12 modalities.

Linda Jackson raised a question around RTT and data quality and asked when performance figures would be available following the implementation of Lorenzo. Adam Creeggan explained he had met with Neil Rogers to work through the opportunities and that a risk log had been created regarding the change in processes; 8,000 additional pathways had been completed. He added that the resolution of issues following the implementation of Lorenzo had been much slower than anticipated, but a new revised timeline would be brought to the next Committee.

Action: Adam Creeggan to bring a revised timeline to the July FEP showing when all issues following the Lorenzo implementation would be resolved.

Gill Ponder raised that the plan to reduce patient follow ups over the last year had not shown much traction and asked what would be different this year. Kate Wood added that this was also linked to 2 amber CQC actions. Paul Bytheway advised that the Planned Care Group had a set of proposals and a plan that would be launched on 4 July 2024 including increased use of Patient Initiated Follow Ups(PIFU).

Gill Ponder raised the 75% late theatre starts at NLAG and suggested that if reduced it could be an opportunity to improve productivity. Paul Bytheway agreed to discuss this with Neil Rogers to understand the late starts in more detail.

Action: Paul Bytheway to bring to the CIC a plan regarding areas of improvement relating to the 75% late theatre starts at NLaG.

Escalation to the Board:

- There are continued concerns regarding ED Performance
- The CIC received positive assurance regarding the progress around the diagnostic trajectories
- Plans were in place for Elective Recovery and Cancer, but were not currently achieving the targets
- The CIC received positive assurance regarding the achievement of removing all 78 week patient waits.

The Committee agreed on limited assurance until plans were fully developed and sustained improvements were being reported. It was acknowledged that there is lots of improvement activity to manage.

Jonathon Lofthouse, Kate Wood, Julie Bielby and Ian Reekie left the meeting at 11am.

Jackie France joined the meeting at 11am.

4.2.1 **Deep Dive – Patient Administration**

Jackie France gave a presentation regarding the Group Outpatient (OP) Transformation programme. The presentation had not yet been presented to the Cabinet.

Jackie France gave an insight to some improvements within the OP area, such as Patient Initiated Follow Up (PIFU) at NLaG which was delivering at 9.4% against the national target of 5%. HUTH were also beginning to embed PIFU. She reported that the validation work was helping to remove patients from the waiting list, where this was appropriate. Digital letters had generated a cost saving of £430k since inception.

Volumes of referrals had reduced as a result of initiatives including Advice and Guidance (A&G) and the Connected Health model in Cardiology. Follow up appointments had reduced, but this had led to an increase in the follow up waiting list at NLaG and a reduction in virtual appointments. Rates of patient's not attending appointments had also reduced prior to the Lorenzo implementation, but had increased since then, possibly due to data quality issues which were being investigated. HUTH had been able to remove 12% of patients from the waiting list by writing to patients to ask if they still needed an appointment. One stop clinics including straight to test were achieving 95% fill rate consistently. Patient Knows Best (PKB) was in use, with 350,000 patients signed up to use it to receive appointment and discharge letters.

She explained that the OP Transformation programme for year 2024-25 will focus around 3 key programmes;

- PIFU by default
- Follow up reduction, validation and reducing waiting times
- Reducing costs and improving patient experience by adopting new models of care across the Group

Paul Bytheway left the meeting at 11.15am.
The CIC was not quorate from this point onwards.

Jackie France updated that the Lorenzo implementation on the South bank went live at the end of February 2024 and following this there had been an increase in staff sickness (5%) and a higher level of staff turnover (13%). The high turnover did include the new vacancies created for the post-implementation support.

Helen Wright queried how the OP Transformation team was working together as a Group. Jackie explained that the programs of work were different across the North and South and there was a plan to create consistency across the Group.

Linda Jackson asked about plans to rollout Connected Health Network ways of working further. Jackie France responded that there were challenges to the scope and scale of rollout, with funding availability a major contributory factor, so the team were focusing on that first.

Jackie left the meeting at 11.23am.

Escalation to the board

- Recruitment of the additional 10 extra validation posts within the Administration team.
- The paper presented to the Committees had not been approved by the Cabinet prior to its presentation, which was outside the agreed process

4.3 **Estates and Facilities – General Update**

Craig Hodgson took the report as read and gave a brief update. He informed the Committee that a new Group parking policy was in draft and included, following review, increased parking charges. This is set to be implemented by December 2024. He added that there were still a lack of non-barrier spaces at

Diana, Princess of Wales Hospital (DPOW), but the team were continuing to increase the number of barrier permits available.

Craig Hodgson updated that there was set to be a price increase at the in-house restaurants at HUTH on the 8 July and a further review of the opening hours would take place. This was needed to negate the loss incurred in the prior year and to harmonise prices across the Group.

Craig Hodgson also updated the group that a review was underway on how cleaning services were provided to the acute sites across the Group. HUTH was currently using OCS and NLAG had an in-house provision.

There were 2 vacant retail units at DPOW; 5 companies had initially expressed an interest, however this had been reduced to 1.

There had only been 1 response to a facilities management tender for the Grimsby and Scunthorpe Community Diagnostic Centres (CDCs). Prices were currently being negotiated as the response received was compliant with Procurement processes.

The committees were advised that 46 good quality Council accommodation units in Elizabeth Row in Scunthorpe had been acquired which would assist with recruitment.

Helen Wright asked a question regarding the Health and Safety Executive (HSE) visit to inspect water services and infrastructure, the potential risks and wondered if the team was confident prior to the visit. Craig Hodgson explained the team were doing everything they could to prepare which included sending information to the inspection team. Lee Bond added that a desktop review was underway, which may conclude that there is no need for a visit.

Simon Parkes queried how the team monitored the implementation of additional grant funding and how much it contributed to savings. Craig Hodgson explained that this information was reported to the Capital meeting and there was governance in place to track the progress. Simon Parkes expressed a view that it would be helpful for the Committee to see the expected savings and investments on the report provided to the PEF. Craig Hodgson confirmed that the recent funding would not deliver savings in 2024/25. Any savings achieved this year would be the result of previous years' investments in such items as solar panels.

Action: Craig Hodgson to provide an overview of the investments and savings within the building estates report.

Craig Hodgson left the meeting at 11.39am.

Escalation to the Board:

- The CIC agreed to highlight the positive funding position and strong management of the harmonised Group Estates programs to the Boards in Common. Furthermore, the additional 46 beds at Scunthorpe would also be highlighted.

The Committees-In-Common agreed that they had received reasonable assurance.

4.4 **Contract Approvals**

There were no contracts for approval.

4.5 **Emerging Issues**

They were no emerging issues raised.

5. ITEMS FOR INFORMATION

5.1 **Work Plan for PEF CiC**

Gill Ponder asked about the missing Procurement report that should have been presented at the May CIC. Lee Bond agreed to bring this to the next meeting in July.

Action: Lee Bond to provide the Procurement Report to the next meeting. This would be added to July's Agenda.

5.2 / 5.3 **Consolidated North Bank Site Report & South Bank Site Report**

Gill Ponder praised the usefulness of the report. She added that she found it enlightening to see the detail of the improvement actions, along with the follow up focus.

5.4 **Planned Care Board Meeting Minutes**

The Committees-In-Common had nothing to raise from the Planned Care Board Minutes.

5.5 **Unplanned Care Board Meeting Minutes**

The Committees-In-Common had nothing to raise from the Unplanned Care Board Minutes.

6. ANY OTHER URGENT BUSINESS

Action: Gill Ponder and Helen Wright to provide information to Lee Bond on what is required in the Finance Report for the next meeting.

7. MATTERS TO BE REFERRED BY THE COMMITTEES-IN-COMMON

7.1 **Matters to be Referred to other Board Committees**

There were no matters for referral to any of the other Board Committees.

7.2 **Matters for Escalation to the Trust Boards**

Items for escalation to the Board were captured in the summaries after each section.

8. DATE AND TIME OF THE NEXT MEETING

8.1 **Date and time of the next PEF CiC meeting:**

Wednesday, 24th July 2024 at 09:00 hours at Diana Princess of Wales Hospital, Grimsby.

Gill Ponder thanked everyone for their attendance and contributions to the meeting, which closed at 11.55am.

Cumulative Record of Attendance at the PEF CiC 2024/2025

Name	Title	2024											
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
CORE MEMBERS													
Gill Ponder	Chair / Non-Executive Director (NED – NLaG)	Y	Y	Y	Y		Y						
Helen Wright	Chair / Non-Executive Director (NED - HUTH)						Y						
Lee Bond	Group Chief Financial Officer	Y	D	Y	Y		Y						
Jane Hawkard	NED (HUTH)	Y	Y	Y	Y		N						
Simon Parkes	NED (NLaG)	Y	Y	Y	Y		Y						
(Shaun Stacey) Paul Bythewa y (from Jun)	Group Chief Delivery Officer	Y	Y	Y	Y		Y						
Dr Kate Wood	Group Chief Medical Officer	D	Y	D	Y		Y						
REQUIRED ATTENDEES													
VACANT	Group Director of Estates	D	D	D	D		D						
Andy Haywood	Group Digital Information Officer	N	N	Y	N		N						
David Sharif	Group Director of Assurance or deputy	D	D	Y	Y		Y						
Alison Drury	Deputy Director of Finance (HUTH)	Y	N	N	N		N						
Brian Shipley	Deputy Director of Finance (NLaG)	Y	Y	Y	N		Y						
Stephen Evans	Operational Director of Finance (HUTH)	Y	Y	N	N		N						
Ian Reekie	Governor Observer (NLaG)	Y	Y	Y	Y		Y						

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)159

Name of Meeting	**Trust Boards-in-Common**
Date of the Meeting	8 August 2024
Director Lead	Kate Truscott & Tony Curry, Non-Executive Directors / Chairs of Workforce, Education & Culture Committees-in-Common
Contact Officer / Author	Amy Slaughter, Personal Assistant
Title of Report	Minutes of the Workforce, Education & Culture Committees-in-Common – May & June 2024
Executive Summary	The minutes attached are the formal account of the meeting. The minutes include any action and resolutions made.
Background Information and/or Supporting Document(s) (if applicable)	The minutes attached are for information.
Prior Approval Process	Workforce, Education & Culture Committees-in-Common on 27th June and 25th July 2024
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

WORKFORCE, EDUCATION AND CULTURE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Thursday, 23rd May 2024 at 13:30 to 17:00 at Boardroom, Alderson House, Hull Royal Infirmary

For the purpose of transacting the business set out below:

Present:

Core Members:

Kate Truscott	Non-Executive Director (NLaG) (Chair)
Sue Liburd	Non-Executive Director (NLaG)
David Sulch	Non-Executive Director (HUTH)
Simon Nearney	Group Chief People Officer
Jo Ledger	Deputy Chief Nurse (HUTH) (Deputy for Group Chief Nurse)

In Attendance:

Rebecca Thompson	Deputy Director of Assurance (HUTH)
Amy Slaughter	Personal Assistant (HUTH) (Minute Taker)
Paul Bunyan	Group Director of Planning, Recruitment, Wellbeing, and Improvement
Robert Pickersgill	Deputy Lead Governor (NLaG) (Observer) (item 1.1 to item 4.8)
Richard Dickinson	Associate Director of Quality Governance (NLaG) (item 3.3.1)
Leah Coneyworth	Head of Quality Compliance and Patient Experience (HUTH) (item 3.3.1)
Maria Briggs	Head of Nursing for Workforce and Research (NLaG) (item 4.1.2)
Wajiha Arshad	Guardian of Safe Working (HUTH) (item 4.4.1)
Richard Horner	Employee Service Centre Manager (HUTH) (item 4.4.1)
Elizabeth Evans	Guardian of Safe Working (NLaG) (item 4.4.2)
Myles Howell	Group Director of Communications and Engagement (item 1.1 to 4.7)
Sean Lyons	Group Chairman (item 4.5 to 4.6)

KEY
HUTH - Hull University Teaching Hospitals NHS Trust
NLaG – Northern Lincolnshire & Goole NHS Foundation Trust

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The committee chair welcomed those present to the meeting. The following apologies for absence were noted:

Tony Curry, Non-Executive Director (HUTH)
Dr Kate Wood, Group Chief Medical Officer
Amanda Stanford, Group Chief Nurse

David Sharif, Group Director of Assurance

1.2 **Declarations of Interest**

No declarations of interests were received in respect of any of the agenda items.

1.3 **To approve the minutes of the meetings held on 30th April 2024**

The minutes of the meetings held on the 30th April 2024 were accepted as a true and accurate record.

1.4 **Matters Arising**

The committee chair invited committee members to raise any matters requiring discussion not captured on the agenda. The following matters arising were discussed:

Simon Nearney declared that the Mutually Agreed Resignation Scheme (MARS) was approved and the window for applications opened on 13th May 2024 with a closing date of 24th June 2024. It was noted that over 100 applications had been received so far.

In 4.3.1 of the minutes of the meeting held on 30th April 2024, the HUTH Freedom to Speak Up Guardian (FTSUG) had agreed to share the proportion of concerns where staff had tried to raise the issue through line management first versus those who had gone straight to the FTSUG however, this had not been shared with the committee. Rebecca Thompson agreed to follow up with the FTSUG.

1.5 **Committees-in-Common Action Tracker**

The following updates to the Action Tracker were noted:

It was agreed that a discussion on the Band 2/3 national profile change would take place at this meeting with a paper circulated following the meeting.

Jo Ledger stated that the senior nursing portfolios had been confirmed and workforce and education were within her portfolio. The difference between the number of Care Hours Per Patient Day (CHPPD) between HUTH and NLaG would be included in future reports. It was agreed to close this action. It was discussed whether CHPPD needed to be discussed at this committee as it was also discussed at the Quality and Safety CiC. It was agreed that CHPPD would still be presented at WECC CIC as it was linked to staff numbers.

Simon Nearney provided an update on the analysis of first year leavers in Administrative and Clerical. In HUTH, there were circa 1000 admin staff who were split into hubs. In Hub 4, there were seven staff members recorded as leaving within the first 12 months however, after further investigation a duplication was found which meant there were only six staff who left within the first 12 months; three of the leavers left for another job outside of the NHS. In Hub 5, there were nine staff members recorded as leaving within the first 12 months. The reasons included returning to education, changing career to nursing, childcare issues and changes in personal circumstances.

The management for the admin team recognised that high turnover was due in part to poor recruitment decisions. In depth interview training was implemented for all those involved in interviews. New starters were now supported with phased inductions where they spend several weeks with other new starters learning the role prior to going into the hubs, local induction takes place once they were assigned their hub, a buddy system and training documentation for each task. Introduction and HR basics training was implemented for all team leaders. The committee was assured by the update, and it was agreed to close the action.

2. MATTERS REFERRED

2.1 Matters referred by the Trust Board(s) or other Board Committees

The committee chair reported that the following matter(s) had been referred by the Trust Board(s) and / or the Capital and Major Projects and Quality and Safety Committees-in-Common for consideration by the committees:

The matter of Group CDC recruitment was raised by the Capital and Major Projects Committees-in-Common.

The matter of the progress of Pharmacy recruitment within NLaG was raised by the Quality and Safety Committees-in-Common.

3. RISK & ASSURANCE

3.1 Board Assurance Framework (BAF)

Rebecca Thompson asked the Committees-in-Common to recommend to the Board the close down of the Q4 workforce and leadership risks for HUTH and NLaG. It was noted that only one risk met its target, which was the HUTH workforce risk. The committee agreed to the recommend the closure of these Q4 risks to the Board.

3.2 Review of Relevant External & Internal Audit Report(s) & Recommendation(s)

There were no external or internal audit report and recommendations to note.

The agenda was taken out of order at this point.

4.1 Registered Nurse & Midwifery Staffing

4.1.1 Registered Nurse & Midwifery Staffing (HUTH)

Jo Ledger shared that the CHPPD for HUTH increased in April 2024, however it was still lower than peers and the national average. To triangulate this information in detail, subsequent papers would include the Trust absence rates for registered and non-registered nursing staff. A focused piece of work was being undertaken regarding nursing establishments.

HUTH was currently 67.54 WTE over-established for registered nurses. The main area of concern for the workforce model was what the agreed over-establishment number would be. The recruitment for students from the University of Hull was completed with 78 Adult students, 7 Paediatrics students and 26 Midwifery

students appointed. There were further students who were appointable, however this would be a cost pressure and would need agreement from the Board.

Appendix 4 showed the number of initiatives that did not have financial agreement and their effect on the establishment. The non-registered nursing vacancies were 58.75 WTE, however 40 of these vacancies were being held to support the recruitment of the Registered Degree Nurse Apprentice (RDNA) and the Trainee Nurse Associate (TNA) work streams. No further international recruitment was planned. In September 2024, 22 TNAs and 12 RNDAs would commence with the Trust, of which 13 were already employed by the Trust.

The University of Hull received feedback from Ofsted regarding the required improvement rating for the apprenticeship programme with HUTH, which increased to a rating of good. The conditional pathway with Hull College for Level 3 Health Care Support Worker (HCSW) apprentices continued, which would allow students to move on to the TNA or RNDA programme following completion. There were seven HCSW Level 3 apprentices currently completing and awaiting final End Point Assessment; two apprentices were moving onto the RNDA programme, and the other five were joining the unregistered workforce in various clinical areas around the Trust.

Following issues raised by midwifery students, the Safe Learning Environment Charter was introduced to provide support to students. It was agreed that Sarah Simons, Practice Learning Facilitator Midwife would present the charter to the committee at the June 2024 meeting.

Action: Jo Ledger to ask Sarah Simons to present the Safe Learning Environment Charter at the June 2024 meeting.

Within HUTH, there was currently over 500 international nurses who were an asset to organisation. Concerns had been raised that retention for international nurses had reduced from 97% to 91%, this was mainly due to the cost of indefinite leave to remain visas. HUTH received recognition for the nurse preceptorship programme. Kate Truscott enquired about the two international students who were on their fourth and final attempt at OSCE, Jo Ledger advised that if the nurses did not pass the examination, they would not be able to remain in England due to visa requirements. The assurance for the HUTH Registered Nurse and Midwifery Staffing was agreed as reasonable.

The agenda returned to order at this point.

3.3 **Review of Relevant External Report, Recommendations & Assurances**

The committee received and considered the following external reports, recommendations and assurances.

3.3.1 **NLAG and HUTH: CQC Actions Progress Report for May 2024**

Richard Dickinson updated that the NLaG CQC report had been refreshed in view of the newly established care group structure. 24 actions were identified as close to closure. Work was ongoing regarding cohesion of compliance teams across the north and south bank to improve consistency for monitoring and assurance. Sue Liburd asked if the actions were being prioritised by the care group leaders,

Jennifer Granger had currently met with 8 of the 14 care groups to identify action leads and there were planned meetings in place with the remaining care groups. Good engagement with the action place was received in the initial conversations. Sue Liburd queried if the Group Cabinet Risk and Assurance Committee see the CQC action plan, it was noted that the CQC Action Plan was reviewed at this Committees-in-Common, Quality and Safety CiC and the Performance, Estates and Finance CiC.

Leah Coneyworth shared that there were 14 open actions on the HUTH CQC action plan which relate to this committee. 20% of clinical staff within ED had completed the De-escalation Management & Intervention (DMI) Training, a trajectory for 40% of the staff to be trained by the end of June 2024 was in place. Jo Ledger advised that she had asked for all band 6 and 7 registered staff to be trained before the end of June 2024 and to ensure that at least one staff member who had been trained was on shift for future rotas as a mitigation. There was also an issue with the provision of future courses, which the training team were trying to resolve.

The safeguarding training rate within Surgery was compliant overall however, the medical staff still needed to reach the target for the action to be completed. The compliance rate for resus training remained at 77%. Jo Ledger stated that she had asked for a cleanse of the data as the data was being skewed by bank staff who were not active. Jo Ledger had also asked all care group Nurse Directors to review the lists of staff within their care groups for accuracy. Kate Truscott asked about the possibility of train the trainers for resus training, Leah Coneyworth advised that resus training was delivered internally. Monthly updates were proved to the CQC regarding the training competencies remain in maternity that were linked to the section 31 notice and trajectories were in place for compliance in June 2024.

The compliance team completed an audit of local induction checklists for temporary staff and a further audit would take place in three months. The HR team were looking at implementing a first 100 days initiative for staff.

Sue Liburd asked about the expected timescale for the DMI training for security staff, it was highlighted that the action had been updated and the training was not required for security staff instead it was for clinical staff within ED.

Sue Liburd questioned the maternity triage deadline, which was not delivered. Jo Ledger advised that the service could demonstrate compliance during the day, which was the original CQC action, however more work was required to achieve the service overnight. The Group Chief Executive had asked for more information on the activity overnight for the maternity triage service at both HUTH and NLaG. It was agreed to adapt the narrative in the report to reflect the change for the maternity triage service.

The assurance for the NLAG and HUTH: CQC Actions Progress Report for May 2024 was agreed as reasonable.

4. COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1.2 **Registered Nurse & Midwifery Staffing (NLaG)**

Maria Briggs shared the significant risk regarding the 94 newly qualified adult nurses and 9 paediatrics nurses that had been recruited per the workforce model, with 63 of those nurses still awaiting confirmation of offer due the over established position that required approval from the Board. Funding from NHSE had been used to appoint a Legacy Mentor to provide nurses at the start of their career with coaching, mentoring and pastoral support. Recruitment continues onto the nursing apprenticeship programs with 34 students on the various programs at present. 11 RNDAs had been recruited to start in September 2024.

Sue Liburd queried the expected attrition rate for the newly qualified nurses awaiting confirmation of offer and what was being done to keep them engaged. Maria Briggs advised that the attrition rate was 15% and the recruitment team were in regular contact with the candidates.

Sue Liburd questioned the freeze on recruitment of international nurses following the amount of investment into Kerala and asked if there was a national freeze on international recruitment. Paul Bunyan advised that at ICB level, there was a business unit for international recruitment, and he was working with other Trusts across the UK regarding international recruitment.

Simon Nearney raised concerns about universities being unable to place all of their nursing students and in turn reducing the number of places available on courses. Simon Nearney asked which university the 11 RNDAs were from, Maria Briggs responded that it was the University of Hull.

Kate Truscott asked how many newly qualified midwives were expected to join the Trust in September 2024, Maria Briggs could not provide the answer and advised there was a rolling recruitment programme for qualified midwives. Sue Liburd asked if students were being recruited by the Group or by the separate Trusts, Jo Ledger advised that it was currently done separately but this would need to be part of the conversation moving forwards. Maria Briggs proposed the idea of rotational posts between HUTH and NLaG for nursing and midwifery students. The assurance for the NLaG Registered Nurse and Midwifery Staffing report was agreed as limited due to the financial constraints.

4.2 **Group Workforce Integrated Performance Report**

Paul Bunyan apologised for the lateness of the report, which was due to delays to the month one closedown for finance, which meant the data required for the report was not available. Committee members would be given access to Power BI and training on how to use the system. Data validation was currently taking place until 31st May 2024. Bugs had been identified in the data for admin staff and trainee grades, which was being worked through. The assurance for the data was currently 85-90%.

The vacancy position within both HUTH and NLaG had reduced. The NLaG vacancy position was driven by nursing and midwifery, with the majority of vacancies relating to Band 6 and above posts, which was being reviewed by the senior nursing team. The consultant vacancy position remained high in Acute and Emergency Medicine, the Care Group were investigating the introduction of SAS doctors and specialist roles.

As Radiology was now in Specialist Cancer and Support Services Care Group, the new care group want to review the established position for interventional radiologists and consider using more trainees etc. The previous position at NLaG was that a fully qualified consultant was required however, this position was not reflected nationally where there were more diverse workforces.

Sickness was within target at both HUTH and NLaG and was continually reducing. The highest absence reasons were anxiety, stress, and depression especially in long term absences. Discussions were taking place regarding what early intervention tools to prevent long term sickness could be used. Access to psychological services and trauma related services was highlighted.

Turnover continued to reduce across the Group. Both Trusts were facing issues with turnover of staff in their first year of employment. Turnover was at a moderate level for consultants, reasons for staff leaving were development opportunities and work/life balance. The introduction of the People Promise Managers would focus on improving the People Promise metrics, including staff work/life balance and maximising opportunities for development for staff.

David Sulch queried the difference in short term sickness between HUTH and NLaG, Paul Bunyan advised that there was no one single reason driving short term sickness. David Sulch asked if there was any correlation between short term sickness and turnover, Paul Bunyan responded that some isolated areas with a higher vacancy position, low staff survey rates and high turnover rates also had a higher amount of short-term absence. Paul Bunyan highlighted that it was part of the HR Business Partner model to triangulate and address these issues.

Kate Truscott asked for agency spend monitoring to be included in the workforce performance report going forwards. Simon Nearney agreed and stated that the headcount numbers would also be included in the report going forwards. David Sulch asked about a different sickness threshold for different areas, Paul Bunyan noted that typically a sickness target was the same for all staff, but this could be considered in the future. The assurance for the Group Workforce Integrated Performance Report was agreed as reasonable.

4.3 **Group Memorandum of Understanding – Shared Workforce**

Simon Nearney shared that the previous Memorandum of Understanding (MOU) was developed during Covid. The new MOU detailed the new operating model across the Group and provided clarity. The MOU included the data sharing agreement, which was previously agreed. The committee approved the Group MOU.

David Sulch asked what a reasonable management process was to ask newly recruited staff to work across the Group. Simon Nearney advised that currently only senior level group based jobs had been advertised but going forwards conversations would be held at recruitment level regarding working across the Group and would be via an agreement not specified in contracts. Sue Liburd asked about resistance from trade unions, Simon Nearney responded that the trade unions had challenged the pace of change and changes that took place without their considerations.

4.4 **Guardian of Safe Working Hours Q4 Report**

4.4.1 **Guardian of Safe Working Hours Q4 Report (HUTH)**

Wajiha Arshad shared that 122 exception reports were received during Q4, the majority of reports were received from General Medicine and Medical Oncology. The majority of exception reports were due to hours worked and missed educational opportunities. Four fines were issued, three of these fines related to non-resident on-call shifts and trainees remaining on site resulting in a breaches of maximum shift length.

89% of rotas were live on eRoster, which was the same as last quarter however, there were a number of rotas that had moved up the categories. The fill rate for Q4 was over 90%, the highest number of trainee vacancies was within Oral and Maxillofacial Surgery. No new themes or trends were identified. The Guardian of Safe Working was working with the Paediatric Surgical Clinical Lead to investigate the rota issues, which forms part a of a larger review of Paediatric Surgery that was currently being carried out.

David Sulch queried the Oral and Maxillofacial Surgery fill rate, Wajiha Arshad advised that historically the medical staffing team had not had sight of this rota and further work was being undertaken to understand the gaps. Kate Truscott asked about the difference between medical staffing managing rotas and clinical teams managing their rotas, Simon Nearney advised that medical staffing provide advice and guidance to all clinical teams who manage their own rotas. The assurance for the HUTH Guardian of Safe Working Hours Q4 Report was agreed as reasonable.

4.4.2 **Guardian of Safe Working Hours Q4 Report (NLaG)**

Elizabeth Evans shared that there was an expected rise in the number of exception reports in Q4, the concerns were scattered amongst specialties and no immediate safety concerns were noted. The majority of exception reports were due to breaches in working hours. No fines were issued during Q4. During Q4, three work schedule reviews took place: one was closed without further action and the other two remained open.

Sue Liburd asked if the junior doctors forum and drop-in sessions were well attended, Elizabeth Evans noted that the attendance for the junior doctor forum had improved due to sending out personalised calendar entries. A face-to-face junior doctor forum was being planned. The assurance for the NLaG Guardian of Safe Working Hours Q4 Report was agreed as reasonable.

The agenda was taken out of order after this point.

4.7 **Group Staff Charter**

Myles Howell presented the Group Staff Charter, which was developed following the work done to determine the staff values. Focus groups discussed and agreed the behaviours required to portray the values and determine the culture of the group. The committee agreed to recommend the Group Staff Charter to the Board for approval.

Sue Liburd asked what the sanctions would be for staff who operated outside of

the charter, Myles Howell replied that the staff charter would be used in disciplinaries and hearings and to challenge behaviours. Simon Nearney added that when the charter was launched, the narrative would include setting expectations and highlight that behaviours that do not conform to the charter would not be tolerated. Myles Howell noted that the staff charter would be built into the appraisal process. David Sulch asked if the charter would be used in values based recruitment, Simon Nearney confirmed that it would form part of process.

The agenda returned to order at this point.

4.5 **Deep Dive – CDC Workforce Update**

Paul Bunyan shared that there were four Community Diagnostic Centres (CDC) in our area: one at Grimsby, one at Scunthorpe and two in Hull and East Riding. The current workforce position across the Group presents risk with both Sonographers and Radiologists. All other roles in scope were on track for delivery for go live.

For Sonographers, it was internationally recognised that this role was hard to fill. The primary mitigation would be the continuation of existing provider contracts until a suitable Sonography workforce could be developed through the existing Radiographer workforce.

For Radiologists, the Care Group Clinical Lead was travelling to Kerala in June 2024 to explore outsourcing models with the aim of reducing the requirement of on-site Radiologists. Currently, the Group use UK contractors at a higher cost. A significant amount of validation work would be required across the ICB to validate security and quality of the reporting. The Care Group were also considering the medical workforce model to establish a delegated model to less senior roles but still with appropriate senior clinical oversight. Previous to 1st April 2024, there were two separate projects groups, which had now been combined into one project group.

Sue Liburd queried the CDC funding for 2025/26, Paul Bunyan noted that this was a risk on the ICB risk register as the CDCs were only government funded for 18 months. Scunthorpe and Grimsby were due to open in October 2024 and the Hull site was due to open in March 2025. Sue Liburd asked if the staff recruited to CDCs would be mobile or site specific, Paul Bunyan responded that the medical staff would be mobile however, the other staff groups would be site specific.

David Sulch asked about the governance for the plan for radiologists to work remotely, Paul Bunyan advised that initially the radiologists would be contracted via outsourcing which already had a governance process in place. It was noted that HUTH currently employ two overseas radiologists who work remotely. The Clinical Lead would be responsible for reviewing and auditing work done remotely in the first instance if the overseas staff were employed directly by the Trust.

David Sulch raised concern with the large gaps in staff even with the plan in place. Sue Liburd asked if a change of government would affect the opening of the CDCs and if they would continue without government funding, Paul Bunyan replied that there was no delay to the opening of the CDCs and the continuation of the CDS would depend on funding and activity levels. The level of recruitment and variables affecting the plan was a concern and noted as a risk amongst the committee.

Action: Paul Bunyan to provide a further update on CDC recruitment in July 2024 with support from the clinical lead and AHP lead.

4.6 **Medical Consultant Workforce Update**

Paul Bunyan shared the short-term plan for a medical workforce review against the establishments of the care groups. The Site Medical Directors were leading the medical workforce review with the Chief's of Service over the next three months to understand the service delivery position and associated workforce position. The main priorities were establishment reviews, group wide job planning review, establishing a Trust Grade pool, clinical leadership PA allocation, reduction in reliance on agency workforce and collective approach to medical education.

David Sulch asked how many PAs were allocated to the Care Group Chief of Service roles, Paul Bunyan replied that 5 PAs were allocated. It was asked what the lead time was for the recruitment of consultants, Paul Bunyan advised that once an offer had been made the lead time to conditional offer was 20 days. It was noted that the Acute and Emergency Medicine vacancy position had not improved for over a year, and it was asked what improvement work had been undertaken. Paul Bunyan responded that last month four posts were converted into specialty posts, which received several applicants. The last two adverts for consultant posts received a strong response, which could be due to the marketing of the new environment and prospective recruits were invited to visit the Trust and meet the teams prior to interview.

Kate Truscott asked about the 23 consultants awaiting start date across the Group and what areas these roles covered. Paul Bunyan could not provide detail in the meeting and would provide the information following the meeting however, some of the consultants under offer might not have Certificate of Completion of Training (CCT) and Cabinet had agreed to not accept any further locum consultants without CCT.

Action: Paul Bunyan to undertake analysis of the 23 consultants under offer and send information to committee members.

David Sulch agreed with the time limit on staff not achieving their CCT but questioned the position on not accepting any further consultants without CCT. Simon Nearney acknowledged that previously the CCT process had not been managed robustly and a report was due to go to cabinet detailing consultants who had not completed their CCT. The assurance for the Medical Consultant Workforce Update was agreed as limited.

Action: Paul Bunyan to bring a further update on consultants without CCT and the impact on the Group to the July 2024 meeting.

<u>NLaG Specific Business Items</u>

4.8 **Deep Dive - Un-Registered Nursing Vacancy Rate**

Paul Bunyan presented the current reported vacancy position for unregistered nursing overall was 10%. The senior nursing teams were carrying out reviews to establish the difference between the reported vacancy position and the actual recruitable position. The recruitment approach was returning to a centralised mass

recruitment approach with more involvement from the Care Groups. The interest received for applications was high however, there were pipeline limitations due to the phased process with circa 20 staff joining a month. Every month the fill rates reduced the adjusted vacancy position to less than 0 because of utilising the vacancy budget for bank staff. One of the risks to the process was the care camp capacity, which limited the number of inductions available.

Kate Truscott asked what the reasons were for the struggle to recruit unregistered nurses, Simon Nearney noted that from a service perspective the roles were filled however due to national minimum wage, the healthcare support worker role salaries were not competitive with other roles available. The healthcare support worker role had a higher turnover than other roles with roughly seven or eight staff leaving per month.

It was noted that apprenticeship numbers were low and the pilot program in place had not been developed fully. Jo Ledger noted that the apprenticeship programme would be part of the establishment reviews and would work with Paul Bunyan and his team to develop the programme. It was highlighted that the work on the Band 2/3 roles could potentially affect the vacancy rate. Sue Liburd sought clarification regarding assessment centres reducing first year leavers, Paul Bunyan stated that assessment centres show the expectations of the role to new entrants. The assurance for the Un-Registered Nursing Vacancy Rate was agreed as reasonable.

4.9 **Nursing Band 2/3 Options**

Jo Ledger agreed to circulate the briefing paper that went to the Financial Planning Improvement Board following the meeting. The campaign driven by the trade unions argued that many band 2 Healthcare Support Workers (HCSW) were performing tasks which fell under the band 3 profile. In collaboration with trade unions, both NLAG and HUTH commissioned individual review processes to determine the specific tasks undertaken by the current band 2 roles. A review of all training and competency programmes aligned with any extended roles was also undertaken to determine the level of competency and skills required to be demonstrated by non-registered nurses completing additional clinical duties/tasks within the clinical setting.

Following the analysis at NLaG, it was identified that on all wards the band 2 HCSW undertook the clinical duties of a band 3, however there was some variation in the frequency these tasks were undertaken. The impact of stopping band 2s from conducting the band 3 clinical duties would have a significant impact on the provision of timely patient care and safety. It was assumed that approximately 50% of the current band 2 roles would need to be uplifted to a band 3.

Following the analysis at HUTH, six areas had band 2 HCSW undertaking the clinical duties of a band 3. For all other areas, the only additional skills that were completed on a regular basis were limited to Urine and Blood Glucose Analysis and removal of Peripheral Cannulas.

The financial implications for NLaG for uplifting 50% of the current Band 2 HCSW was potentially £1.2m annually. If staff were to receive back pay, the cost for three years would be £4.5m and for six years would be £8.5m. The financial implications

for HUTH for the 30 staff identified was £103k for the uplift, £367k for three years back pay and £734k for six years back pay. The potential costs associated with uplifting all Band 2 staff at HUTH to Band 3 was £1.8m for the uplift, £4.8m for three years back pay and £8.6m for six years back pay.

The recommendations were:

- to conclude whether Urinalysis, Blood Glucose monitoring and Peripheral Cannula removal were deemed sufficient to justify the uplift of the current band 2s in HUTH to band 3
- clarify roles and associated skills required to deliver safe services for each ward and department 24/7 across the Group
- undertake a tabletop exercise of job descriptions to determine scope of practice
- develop a consistent approach to the completion of establishment reviews for all clinical areas across the Group and ensure robust processes are in place to prevent future role creep.

It was agreed that a verbal update would be provided at the next meeting.

4.10 **Pharmacy Recruitment Progress Update**

Paul Bunyan shared that the vacancy position of band 6 and above posts within Pharmacy at NLaG was long standing position. The vacancy position was offset by an over establishment of band 4 Pharmacy Technicians, who were able to partially fulfil the role of a pharmacist but only in an unregistered capacity. The Pharmacy management team have had to act down at time to provide service at ward-based level. The service was able to deliver a safe service provision however, this service was only at a basic level. The report highlighted the extensive activity that the department were undertaking on an on-going basis to continue to attract candidates. Currently, there was seven Band 6 vacancies with two candidates appointed and awaiting start dates, 3.6 WTE pre-registered pharmacists were due to join the department in September 2024.

It was highlighted that the fundamental difficulty in attracting staff was the significant salary difference with the private sector. Simon Nearney noted he had spoken with the HUTH Chief Pharmacist regarding providing support to NLaG. It was acknowledged that the long-term answer was more junior pharmacists and trainees included in the workforce model. It was agreed to defer the item back to Quality and Safety in case any quality issues were emerging.

5. ITEMS FOR INFORMATION / TO NOTE

5.1 The workplan was noted and discussed.

Action: An update on leadership programmes across the Group to be presented at the July 2024 meeting with a report in October 2024 detailing the new Group leadership programmes.

6. ANY OTHER URGENT BUSINESS

There were no items of any other business raised.

7. MATTERS TO BE REFERRED BY THE COMMITTEES

7.1 **Matters to be Referred to other Board Committees**

There were no matters for referral to any of the other board committees.

7.2 **Matters for Escalation to the Trust Boards**

It was agreed that the following matters required escalation to the Trust Board(s) in the committees' highlight report:

- The University of Hull had received a 'good' Ofsted rating which had been influenced by the HUTH apprenticeship programme amongst other improvements.
- HUTH International Nurse retention had reduced from 98% to 91% due to the increased Visa costs.
- The Group Staff Charter was recommended for approval.
- HUTH/NLAG CDC risks – The CIC was assured that there was a plan in place but there were many variables such as finance, governance, remote reporting and recruitment that could impact on it.
- Band 2/3 project financial implications.

8. DATE AND TIME OF THE NEXT MEETING

8.1 **Date and Time of the next Workforce, Education and Culture CiC meeting:**

Thursday, 27th June 2024, at 13:30, in the Boardroom, Alderson House, Hull Royal Infirmary.

The committee chair closed the meeting at 16:50 hours.

Cumulative Record of Attendance at the Workforce, Education and Culture Committees-in-Common 2024/2025

Name	Title	2024 / 2025											
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
CORE MEMBERS													
Simon Nearney	Group Chief People Officer	Y	Y										
Amanda Stanford	Group Chief Nurse	D	D										
Kate Wood	Group Chief Medical Officer	Y	N										
Tony Curry	Non-Executive Director (HUTH)	N	N										
Kate Truscott	Non-Executive Director (NLaG)	Y	Y										
David Sulch	Non-Executive Director (HUTH)	Y	Y										
Sue Liburd	Non-Executive Director (NLaG)	Y	Y										
REQUIRED ATTENDEES													
David Sharif	Group Director	Y	D										

	of Assurance												

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

WORKFORCE, EDUCATION AND CULTURE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Thursday, 27th June 2024 at 13:30 to 17:00 at Boardroom, Alderson House, Hull Royal Infirmary

For the purpose of transacting the business set out below:

Present:

Core Members:

Tony Curry	Non-Executive Director (HUTH) Chair
Kate Truscott	Non-Executive Director (NLaG)
Sue Liburd	Non-Executive Director (NLaG)
David Sulch	Non-Executive Director (HUTH)
Simon Nearney	Group Chief People Officer
Dr Kate Wood	Group Chief Medical Officer
Amanda Stanford	Group Chief Nurse

In Attendance:

Rebecca Thompson	Deputy Director of Assurance (HUTH)
Amy Slaughter	Personal Assistant (HUTH) (Minute Taker)
Lauren Rowbottom	Personal Assistant (HUTH) (Minute Taker)
Paul Bunyan	Group Director of Planning, Recruitment, Wellbeing, and Improvement (Item 4.1)
Leah Coneyworth	Head of Quality Compliance and Patient Experience (HUTH) (item 3.3.1)
Jennifer Granger	Head of Compliance and Assurance (NLaG) (Item 3.3.1)
Ajay Chawla	Clinical Dean NLAG (Item 4.3.1)
Robert Desborough	Clinical Dean HUTH (Item 4.3.2)
Kathryn Hallam	Undergraduate Education Manager (Item 4.3.2)
Sean Lyons	Group Chairman
Lucy Vere	Group Director of Learning and Organisational Development (Item 4.2.1 to 4.2.2 and Item 4.4 to 4.5)
Jo Ledger	Group Deputy Chief Nurse (Item 4.7)
Helen Knowles	Group Director of People Services (item 5.2)
David Sharif	Group Director of Assurance
Ashok Pathak	Associate Non-Executive Director

Observers:

Robert Pickersgill	Deputy Lead Governor

KEY
HUTH - Hull University Teaching Hospitals NHS Trust
NLaG – Northern Lincolnshire & Goole NHS Foundation Trust

1. CORE BUSINESS ITEMS

1.1 **Welcome and Apologies for Absence**

The committee chair welcomed those present to the meeting. There were no apologies received.

1.2 **Declarations of Interest**

No declarations of interests were received in respect of any of the agenda items.

1.3 **To approve the minutes of the meetings held on 23rd May 2024**

The minutes of the meetings held on the 23rd May were accepted as a true and accurate record.

1.4 **Matters Arising**

The committee chair invited committee members to raise any matters requiring discussion not captured on the agenda. The following matters arising were discussed:

Kate Truscott mentioned a matter arising following an email from the Freedom to Speak Up Guardians (FTSUG) outlining staff who had raised concerns with their line managers first. 201 cases where reported to the FTSUG, of those 83 had involved their line manager first and 113 had not, 5 where not categorised.

Kate expressed thanks to Paul Bunyan for providing additional information to the Committee following a conversation at the last Committee around Consultant Recruitment.

Simon Nearney gave a verbal update on the MARS Scheme. 260 applications had been received and decisions on successful applicants would be decided by the 24th July with an aim for staff to leave by the end of August. All successful applicants are to be discussed at the Remuneration Committee.

Ashok Pathak raised the question around the consultant vacancy position and the delay in appointment whether this was down to waiting for accreditation or a delay in the Royal College. Simon explained it was subject to job plan approval by the Royal College.

1.5 **Committees-in-Common Action Tracker**

The following updates to the Action Tracker were noted:

7.1 Workforce Race Equality Standard (WRES)
Lucy Vere updated that Mano Jamieson and Helen Knowles had met to discuss how Hull York Medical School (HYMS) may help to support anti-racism across the Group. Mano Jamieson was providing information regarding the zero tolerance to racism tool and this would be included in the September report. Feedback from the staff networks showed a trend of the same 3 themes; Recruitment, Progression and Careers and Bullying and Harassment.

Action: Lucy proposed a deep dive in September's meeting regarding the experiences of international workers. The CIC supported this.

Lucy updated that Carla Ramsay had submitted a paper to Cabinet regarding staff from a black, Asian and minority ethnic, to help ensure all opportunities are available. She added that this would help the Group refresh the anti-racism statement, and the zero tolerance to racism tool. Amanda Stanford added that the Communications team were putting a message out to the Group around the political narrative of international nurse recruitment. Ashok added that the Group was doing everything possible for international Doctors and Nurses and offered his help if needed. The Chairman added that he would be discussing NED alignment with the Care Groups at the next Non-Executive Directors (NEDs) meeting.

4.5 Group Values

The CIC discussed the current culture following the results from the quarterly Pulse Survey and it was agreed that a deep dive into the recent Barratt Survey results regarding staff engagement and feeling valued was required. It was believed that the Group was still operating a command and control environment and staff were feeling pressured in their work. This deep dive would be received at the July 2024 CIC. Lucy added that a cultural dashboard was being created to help improve peer to peer behaviours, civility and respect.

Action: Culture to be added as a standing item on the agenda.

Action: Lucy Vere and Simon Nearney to bring a report to the next CIC regarding the organisations culture and staff experiences.

4.6 Consultant Recruitment

Paul Bunyan gave a summary on the Consultant vacancies which had risen from 23 to 25 across all Care Groups. He noted the two areas of concern were Specialist Cancer Support Services and Acute and Emergency Medicine. Simon asked how long it would take before the 25 consultants would be working in the Trusts and Paul informed him it would take 3 months. Ashok asked if there were any backup measures in place to support Consultants and ensure there would be no breaks in service. Paul explained all projects were being managed centrally by the Clinical Leads who were giving ongoing support.

The assurance for the Consultant Recruitment was agreed as limited.

2. MATTERS REFERRED

2.1 Matters referred by the Trust Board(s) or other Board Committees

There were no matters referred to the CIC.

3. RISK & ASSURANCE

3.1 Board Assurance Framework (BAF)

David Sharif took the report as read and advised there had been no movement on the risk ratings since the last report. Sue questioned whether the Cultural and

Leadership risk rating was correct following the earlier discussion around staff culture. It was agreed at July's meeting, the Committee will review the BAF Risk Rating for Cultural and Leadership as part of the Barratt Values deep dive.

Action: Review the BAF Risk Rating for Cultural and Leadership.

3.2 **Review of Relevant External & Internal Audit Report(s) & Recommendation(s)**

There were no external or internal audit report and recommendations to note.

3.3 **Review of relevant External Reports, Recommendations & Assurances as appropriate**

3.3.1 **NLaG and HUTH: CQC Actions Progress Report for June 2024**

NLaG:
Jennifer gave a brief overview of the report. She informed the CIC that work was underway to align the North and South reports, and they would be using the same terminology and report template going forward. Since the last report 3 actions had been closed and 22 remained open. 12 of which were amber and the others were green. The 4 themes related to Culture and Leadership, Appraisals, Mandatory training and Supervision and End of Life Medical Training.

David Sulch agreed with realistic timescales but queried whether some actions should be rated red as their targets hadn't moved and queried what was being done differently to achieve the new targets. Jennifer explained the targets and deadlines were being reviewed.

Amanda Stanford stated she was conscious that the assurance level for Cultural and Leadership was green and was this accurate in light of the earlier conversation. Jennifer advised that a planning group approach was underway and they would be undertaking assurance visits between the North and South sites and speaking to staff.

HUTH:
Leah Coneyworth gave an update on the HUTH report. She informed the Committee that there were 14 actions linked to WEC CiC and not 10 as the report stated. The main risk areas which were rated red where Security Training within the Emergency Department, and Resus Training which was at 77% compliance and had shown no improvement in the last 3 months. Fetal monitoring had improved from 85% to 87% and newborn life support had improved from 76% to 87%.

Jo Ledger explained that the De-escalation and Management Intervention Training for Clinical Staff was rated red but it didn't need to be as there was no requirement across any ED Departments requiring all staff to be DMI trained.

Simon Nearney queried the target dates and the escalation process. Leah explained there was a check and challenge meeting in place and maternity had the Maternity Transformation Assurance Committee (MTAC) were actions would be escalated through the HUTH CQC Section 31 Delivery Group. The trust wide actions followed a similar approach along with ED Safety Champions but due to changes within the Group and structure these had not happened recently.

Action: The CIC agreed that all CQC Actions needed a refresh.

The CIC gave no assurance to the NLAG/HUTH CQC Actions report.

4 COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 Group Workforce Integrated Performance Report Including time to Hire KPI / Update on 23 Consultant Vacancies

Paul Bunyan took the report as read, and informed the Committee that everyone now had access to the live month to month data sets on Power BI and offered training support if required.

Turnover was stable throughout the group but Health Care Assistant (HCA) and Admin Workforce was driving the higher turnover figure. The exit questionnaire showed the main themes to leaving were work life balance and opportunities to progress. The overall vacancy position had seen a reduction of 30 WTE. Paul explained that longer term analysis showed that a year ago HUTH had 99 Medical Dental Vacancies which now showed at 27, NLaG had 159 vacancies and now had 104.

Sickness was showing a reducing trend over the last 12 months, was still stable and had not spiked in any areas. The main driving points again were Estates and HCA.

Helen Knowles gave an update on the NLaG nursing agency hours which had reduced dramatically from the 1st of January. In January there were 411 hours ofNLaG framework usage and this had reduced form 2653. She added that the Group was on trajectory to have no off framework usage by the 1st of July. Helen reported that week commencing 10th of June there had been 124 hours of agency usage.

Ashok Pathak gave thanks for the positive news and raised a query on how the team were trying to bridge the gap in the current vacancy position at NLaG. Paul explained that the Chiefs of Service and Operational Directors were reassessing what their establishments looked like and developing plans to fill the gaps. Paul added that workforce redesign were helping with recruitment and updated that UEC had recently translated consultant positions into specialist roles and this had helped with recruiting to all the roles.

Simon Nearney gave an update on the Medical and Dental medical agency reduction and stated it was moving in the right direction. From April to date there had been around 400-500 hours reduction of medical agency usage on the South Bank. On the North Bank there had been a reduction of around 150. There was only 1 Doctor off framework from the 1st of July and this was in Haematology. Appraisals at HUTH of all staff excluding medics was at 84.5%, including medics was 91%. NLaG all excluding medics was 83.2% and including medics was at 82%.

David Sulch queried whether stress, anxiety and depression was an NHS wide or Humber specific cause of sickness and if they anticipate this will be worsened by the loss of the resilience hub from the ICB. Paul expressed that stress, anxiety and depression was a typical trend across the NHS. He also added that they was engaging with a company to bring in an employee assistance programme that offered face to face and family counselling, legal advice and financial planning.

Dr Kate Wood expressed it was unusual that the NLaG data for appraisals was below 90% and requested the team to recheck the data.

Kate Truscott stated that the information given indicated challenges regarding job planning. Dr Kate Wood added she was doing a piece of work with Helen Knowles around job planning across the group, and it was proving complex due to planning frameworks being slightly different across the North and South. David Sulch added he was comfortable with the position and would rather have well done job plans that took longer to develop over rushed ones.

Sean Lyons queried whether exit interviews were mandated. Paul explained it was on a discretionary basis and employees were sent an email with a link to complete upon leaving the Group.

Jo Ledger updated on the HUTH Nursing and Midwifery Student recruitment. 80 adult and paediatric staff had been recruited, 56 of those had been allocated and 17 were hoping to be placed shortly. 12 had not being offered any post. NLaG had agreed 103 and 65 had been allocated. A number of Band 6 midwife vacancies would be filled with Band 5 staff and the Band 5 posts would be back filled with allocated students.

The agenda was taken out of order after this point.

Undergraduate Medical Education – Six-Monthly Progess/Exception Report

4.3

Undergraduate Medical Education – Six-Monthly Progess/Exception Report (NLaG)

4.3.2

Ajay Chawla took the report as read. He highlighted that NLaG had been supporting 554 students a year since 2005, and HYMS (Hull York Medical School) 468 students. The approximate budget was around £4m and this helped with tutoringtime and supporting placements. The main aim was to announce the local recruitment of doctors and this year NLaG was getting 6 FY1s.

Ajay gave an explanation on the placements for the Students. Governance was done by the annual monitoring visit from HYMS and Sheffield. The latest report stated the Trust was providing high quality placements for all medical students and had met all assurance standards as part of the quality improvement process. Local feedback had also been reported as good. Some issues regarding women's health had been raised and the team were trying to address this locally in collaboration with HYMS.

One of the risks raised was regarding money and limited space in accommodation and space within HYMS and tutor time. 6 inductions were provided per year for HYMS, and 7 for Sheffield, any increase in the numbers may prove to be a

challenge. He added that they were looking at how to support placements when some services were being centralised.

Ajay concluded that they were a very small team, but every year the tutors and HYMS team were being nominated by students for the excellence awards.

Kate Truscott thanked Ajay for the report and expressed that it was great to see the feedback. She queried simulation skills and what facilities NLaG had and what the opportunities may be now that the service was part of the Group. Kathryn Hallam explained that there was an undergraduate centre at each site, and each one had a large clinical skills lab. Ajay added that there was a plan to share a simulation practice across the Group.

Sean Lyons gave thanks for the report. He queried whether the team receive any comments regarding the quality of accommodation for Junior Doctors in Scunthorpe and Grimsby and if they receive any feedback from students. Ajay explained that Grimsby and Scunthorpe had new accommodation. It was reported that students were requesting more bedside teaching andonversations were underway with the teaching fellows and women's health to try and get a shared teaching fellow using the same model as HUTH.

Sue Liburd wondered whether the new Care Group structure was having a negative impact on protected teaching time and job planning. Ajay expressed that they had not seen a significant impact and Kathryn agreed but advised that the data had been taken from April 2024 when student numbers decrease.

Ashok Pathak gave congratulations to the team for retaining more HYMS graduates.

4.3.1 **Undergraduate Medical Education – Six-Monthly Progess/Exception Report (HUTH)**

Robert Desborough took the report as read and stated that a lot of the things reported on in the South Bank report mirrored the North. A difference was that there had been an 84% increase in year 1 and 2 student numbers and feedback had improved significantly. t In house feedback showed improvement and thisdue to changes being made by the clinical teaching fellows.

The team had recruited Clinical Deans to help with the overall improvement in areas and Biju Cherian had been working to help improve the the Acute Care block. He added it had been a great achievement despite the barriers and pressures but also noted that students were coming back to inform them of negative and hostile experiences on the wards.

Lucy Vere invited both HUTH and NLaG teams the opportunity of the Spark Simulation Partnership for advancing regional knowledge.

Sean Lyons queried whether HUTH and NLaG were seen as good places to work and were they receiving any feedback from students regarding the reputation of the organisations or any emerging cultural issues. Robert stated noand added that a lot of the HYMS graduates come back to work at HUTH and an example of this being the CTF role which received 500 applicants.

Dr Kate Wood informed the CIC that the next reports would be in the Group format with the 2 reports using the same template. She praised the fantastic work the teams were doing and stated the future challenge would be the rise in placements across the North and the South.

Kate Truscott gave thanks to all the teams who supported the students.

The CIC agreed significant assurance for the Undergraduate Medical Education processes and outcomes.

Deep Dive – Group Required Learning

4.4

Lucy Vere took the report as read. Group wide compliance was below target for resuscitation and information governance. The South Bank had experienced issues with Safeguarding adult's level 3, Safeguarding children and young people level 3 and fire safety for clinical staff. Lucy added that a different approach around required learning across the Group was needed. A proposal had been made to establish aRequired Learning Steering Group and also plans to create a working group to support Medical and Dental trainees, working closely with the HR Business Partners.

Lucy updated regarding the planned changes to the core required learning. All staff on induction from August would be required to complete their required learning on day 1 and training spaces for staff to complete their training were being identified. She added that the Group was reviewing an e-learning passport which would be compliant at all NHS trusts. There was also the opportunity for teams to review their required learning and how compliance would be managed. Lucy was working with NLAG to formulate Groupwide solutions.

Amanda Stanford was also working across the patch to review mandatory training for the nursing teams..

David Sulch queried whether it was feasible for staff to have a mandatory training day and to do it off site so staff were not pulled back into clinical areas. Lucy added that timetables were challenged with medical staff, but this would be reviewedin the Required Learning Steering Group.

Kate Truscott raised concerns around potential conflicts and what learning would and would not be included. She stated that required learning was also the responsibility of the individual to complete but also within the role of the line manager and linked to appraisal. Lucy assured the CIC that the new induction programme would help.

Sue Liburd suggested the Steering Group could look at the issues and the consequences of staff not completing their e-learning and the periods of grace given to people to ensure completion. Lucy explained the Steering Group will be up and running by July 2024 and an update would be received at the CIC in September 2024.

Action: Lucy Vere to bring a non-medical learning report to Septembers CIC, alongside a planned programme for required learning for approval.

4.5 The CIC agreed limited assurance for the Group required learning.

Deep Dive – Group Training Spaces

Lucy Vere took the report as read. She explained that the variety of rooms and facilities at NLaG were not dissimilar to HUTHs, and once the Innovation and Learning Centre was completed in December this would give much more capacity. She added that the learning spaces at NLaG were not fit for purpose and needed updating, however the Lecture Theatre at Scunthorpe General Hospital had been refurbished along with other training spaces.

Lucy explained that access to facilities on the SouthBank had a system called 'Bookwise' which was a central diary system allowing all teams to see all available rooms. Lucy expressed she would like to get central control of all the rooms within the Group to allow teams to view training room capacity.

The CIC discussed the work carried out so far and the amount of work still to do to regarding how the training programme would work and what the facilities would look like.

Action: Lucy Vere to bring back a deep dive update on the Group Training space in November 2024.

The CIC agreed the assurance rating for the Group Training Space update was limited, but the work to date was acknowledged.

4.2 **Modern Slavery Statement**

4.2.1 **Modern Slavery Statement – HUTH and NLaG**

Lucy Vere presented the statements and outlined the training, policies and procedures in place to support the statement.

Sean Lyons expressed he was fine with the statement providing due diligence had been carried out, particularly through the procurement processes.

The Committees-In-Common gave approval for the Modern Slavery Statements for HUTH and NLaG to be submitted to the Trust Board.

The agenda returned to order at this point.

4.6 **Medical Engagement Update (Monthly)**

Dr Kate Wood started the update on the Medical Engagement Update with positive news that a Medical Engagement and Leadership Strategy had been agreed for the Group. She added this would be presented to the WEC CiC in July 2024 for oversight.

Action: Dr Kate Wood to bring the Medical Engagement and Leadership Strategy to July 2024 CIC..

Dr Kate Wood updated the CIC regarding the consultant concerns which primarily related to pay rates. She advised that she was meeting regularly with the South Bank consultants, but there was a reluctance on the North Bank for a Trustwide forum.

Dr Kate Wood informed the Committee that she had attended the Secondary Care Conference and over 100 people had attended, 80 of which were consultants from the North and South. Work was underway with planning the consultant conference for October 2024.

All clinical leads had been put at risk following the new Care Group restructure, and new job descriptions had been written to allow individuals to apply for new roles. Dr Kate Wood reported this had landed well and gave opportunities for staff to apply for leadership roles.

Ashok Pathak questioned the difficulty on the North bank with the consultant forum and Dr Kate Wood advised that it was not held regularly but there were meetings held but on an ad hoc basis.

Sean Lyons asked what the takeaways where from the Primary Care Conference. Dr Kate Wood explained that the primary focus was around how follow ups would be managed in the future and the impact of delayed follow ups on Primary and Secondary care.

4.7 **Nursing Band 2/3 Options**

Jo Ledger updated that a Task and Finish Group had been set up and was in the process of reviewing all job profiles and descriptions. She stated she had a positive meeting with the Unions on the North and that they were keen to work in collaboration. She added that she would be meeting with the North Band 7's and the Unions regarding this matter.

Jo advised that she had met with the South Bank Band 7s and they had been positive and engaged. A work plan was being developed and meetings with the Unions were being arranged.

The CIC agreed reasonable assurance for the Nursing Band 2/3 issue due to the processes and action plan now in place.

5. ITEMS FOR INFORMATION / TO NOTE

5.1 The work plan was noted and there were no issues raised. It was agreed that Culture should become a standing agenda item and this would be added to the workplan.

5.2 **Trade Union Facility Time Requirements**

The report was received as information and no questions were raised.

6. ANY OTHER URGENT BUSINESS

Tony Curry advised that the September 2024 meeting of the WEC CIC would be a workshop/timeout to review the CIC workplan and how the CIC was operating so far.

7. MATTERS TO BE REFERRED BY THE COMMITTEES

7.1 Matters to be Referred to other Board Committees

There were no matters for referral to any of the other board committees.

7.2 Matters for Escalation to the Trust Boards

It was agreed that the following matters required escalation to the Trust Board(s) in the committees' highlight report:

- The approved Modern Slavery Statement for HUTH and NLaG
- The Undergraduate Medical Education Report to be highlighted at the Boards in Common regarding the good work being done and the significant assurance due to the processes in place
- The Culture discussion and how the Staff Survey Pulse results were not showing positive change
- Nursing band 2/3 options and the potential financial impact on the Group.

8. DATE AND TIME OF THE NEXT MEETING

8.1 Date and Time of the next Workforce, Education and Culture CiC meeting:

Thursday, 25th July 2024, at 13:30, in the Main Boardroom, Diana Princess of Wales Hospital.

The Committee chair closed the meeting at **16:45 hours**.

Cumulative Record of Attendance at the Workforce, Education and Culture Committees-in-Common 2024/2025

Name	Title	2024 / 2025											
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
CORE MEMBERS													
Simon Nearney	Group Chief People Officer	Y	Y	Y									
Amanda Stanford	Group Chief Nurse	D	D	Y									
Kate Wood	Group Chief Medical Officer	Y	N	Y									
Tony Curry	Non-Executive Director (HUTH)	N	N	Y									
Kate Truscott	Non-Executive Director (NLaG)	Y	Y	Y									
David Sulch	Non-Executive Director (HUTH)	Y	Y	Y									
Sue Liburd	Non-Executive Director (NLaG)	Y	Y	Y									

REQUIRED ATTENDEES													
David Sharif	Group Director of Assurance	Y	D	Y									

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)160

Name of the Meeting	Trust Boards-in-Common (meeting held in Public)
Date of the Meeting	08 August 2024
Director Lead	Dr Kate Wood, Group Chief Medical Officer
Contact Officer/Author	Helen Fitzpatrick, Revalidation and Appraisal Co-Ordinator, NLaG Jane Heaton, Associate Director of Strategic, Medical Workforce, NLaG Oliver Miskin, Senior e-Medical Workforce Officer, HUTH Dr Ananthakrishnan Ananthasayanam, Group Associate Chief Medical Officer and Responsible Officer, HUTH
Title of the Report	Medical Revalidation/Responsible Officer Report – Annual Revalidation Report 2024/Annual Organisational Audit Report (AOA)
Executive Summary	The purpose of this AOA Board Report is to guide organisations by setting out the key revalidation and appraisal requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore: • help the designated body in its pursuit of quality improvement • provide the necessary assurance to the higher-level responsible officer • act as evidence for CQC inspections This report is an element of the Framework of Quality Assurance for the appraisal and revalidation of doctors, and this is a standard reporting mechanism for all Responsible Officers to complete and return. The reports for each Designated Body have to remain separate but will have aligned detail contained within them for the coming years. **NLaG:** NLaG can demonstrate standard compliance and the continual improvement, as demonstrated by the completion of the external audit recommendations (the audit report is attached). No doctor missed an appraisal without an agreed exception in place. **HUTH:** Attention needs to be drawn to the lack of appraisers within HUTH currently, which may impact on the ability to provide annual appraisals. This will be a focus of attention for the coming year, particularly looking at group wide solutions. The Workforce, Education and Culture Committees-in-Common are asked to note this paper and recommend Trust Board sign off for submission to NHSE.

Background Information and/or Supporting Document(s) (if applicable)	Medical revalidation was launched by the Department of Health and Social Care and the General Medical Council in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety, and increasing public trust and confidence in the medical system. This is an annual report that is signed off by the Trust Board and sent to NHS England to confirm compliance with Appraisal and Revalidation. The report provides assurance of what has taken place over the last year and what is a focus for the coming year.
Prior Approval Process	Workforce, Education and Culture Committees-in-Common meeting held on 25 July 2024
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

NLaG Annual Revalidation Report 2024

Contents

1. Background to appraisal and revalidation

Medical revalidation was launched by the Department of Health and Social Care and the General Medical Council in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety, and increasing public trust and confidence in the medical system. It was launched to be a proactive system of ensuring doctors are fit to practice in the UK. The revalidation process was not designed to "catch out" doctors who were not practising to the accepted standards as laid down by Good Medical Practice.

Prior to the introduction of revalidation there was no consistent mechanisms of ensuring doctors were fit to practice and if there were concerns around fitness to practice, a patient had already come to harm. The General Medical Council also stated that they believed it was important for regulators to be in continuous contact with registered doctors throughout their career, and not just when the General Medical Council are investigating a doctor.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations and it is expected that executive teams will oversee compliance by:

- Monitoring the frequency and quality of medical appraisals in their organisations
- Checking there are effective systems in place for monitoring the conduct and performance of their doctors.
- Confirming that feedback from patients and colleagues is sought periodically so that their views can inform the appraisal and revalidation process for their doctor.
- Ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are conducted to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

All doctors are allocated to a designated body through the General Medical Council. Northern Lincolnshire and Goole NHS Trust is the designated body for all our non-training grade doctors such as Consultants, Specialty Doctors, International Training Initiative doctors and Trust Grade doctors. Dr Kate Wood is the Responsible Officer (Responsible Officer), and Mr Ajay Chawla is the Appraisal Clinical Leader for the Trust.

Doctors in training are connected to the deanery (Health Education England – Yorkshire and Humber) and locum agency doctors are connected to their respective locum agency for revalidation. Therefore, these groups of doctors are not included in this report.

2. General Information

2.1 Medical appraisal and Revalidation and Good Medical Practice 2024 update

On the 30th of January 2024, new professional standards for doctors came into effect. The new guidance saw the first substantial changes to *Good Medical Practice* since 2013.

The new guidance saw updates in five key areas, creating respectful, fair, and compassionate workplaces; promoting patient centred care; helping to tackle discrimination; championing fair and inclusive leadership; and supporting continuity of care and safe delegation.

From a medical appraisal perspective, the GMC expect appraisal software providers to update the appraisal form by April 2025.

"L2P" the appraisal software provider for NLaG, has updated the appraisal form to reflect the new guidance and has been implemented.

2.2 Responsible Officer Role

Dr Kate Wood, Group Executive Chief Medical Officer, is the nominated Responsible Officer for this Trust. The Responsible Officer has received Responsible Officer training and is a licensed medical practitioner. Therefore, Northern Lincolnshire and Goole NHS Foundation Trust is compliant with Regulation 5 of The Medical Profession (Responsible Officers) Regulations 2010.

The Responsible Officer also attends the NHS England and NHS Improvement quarterly Responsible Officer network meetings and best practice is shared with the Clinical Lead for Appraisal and the Revalidation Coordinator.

The Responsible Officer also makes recommendation of revalidation to the General Medical Council for doctors who are due to revalidate. These recommendations are based on an evidence-based approach which consist of appraisal output summaries which are submitted by the appraisers.

2.3 Funds, capacity, and resources

To date the organisation has been compliant with Regulation 14 of The Medical Profession (Responsible Officers) Regulations 2010, which states that each designated body must provide the appointed/nominated Responsible Officer with sufficient funds and other resources necessary to enable the Responsible Officer to discharge their responsibilities.

2.4 Records of Northern Lincolnshire and Goole NHS Foundation Trust licensed medical practitioners

The Revalidation and Medical Appraisal Coordinator is the Trust-wide coordinator who maintains records of Northern Lincolnshire and Goole NHS Foundation Trust licensed medical practitioners. This includes.

- General Medical Council Connect: A database of Medical Practitioners who have a prescribed connection to Northern Lincolnshire and Goole NHS Foundation Trust where the revalidation recommendations are submitted.

- L2P Appraisal software system. All Medical Practitioners who are on the Northern Lincolnshire and Goole NHS Foundation Trust General Medical Council connect database will have an L2P account which is an online appraisal system.

To ensure that these lists are accurately maintained, the Revalidation and Medical Appraisal coordinator exports starter and leaver reports from Business Intelligence system on ESR.

2.5 Northern Lincolnshire and Goole NHS Foundation Trust Medical Appraisal Procedure policy document

This procedure was approved on 03/07/2023 and will be due for review in July 2026. (DCR100)

2.6 Short-term placement and locum doctors

Short term contract holders, such as NHS locum Consultants, fixed terms speciality doctors and Trust Grade doctors, are supported in their continuing professional development (CPD), revalidation and governance in coherence with substantive medical staff, i.e., they are not considered or managed differently to permanent medical staff.

Short term contract holders are expected to maintain their professional development through the appropriate Trust processes, such as Study leave, participating in mandatory training and attending medical teaching sessions. They are also expected to engage with medical appraisal and revalidation.
Upon appointment short term contract holders are incorporated into the local appraisal software system, L2P, are duly welcomed by the coordinator via email, advised of medical appraisal 1:1 session, and the General Medical Council are informed that the doctor has a prescribed connection to Northern Lincolnshire and Goole NHS Foundation Trust.

In terms of governance all new short-term contract holders are initially made aware of governance procedures, such as incident reporting, through the Trust's induction Policy as are all new starters to the Trust.

3. Ensuring Effective Appraisal and Appraisal Data

3.1 The Medical Appraisal

Doctors who have prescribed connection to Northern Lincolnshire and Goole NHS Foundation Trust use the L2P software system. The doctors are required to fill their appraisal form via the L2P system and there are three basic elements to the appraisal.

1. Appraisal Inputs – doctor fills in each section of the L2P form and uploading supporting information/evidence which covers their scope of practice, which may include non-NHS work. The doctor must cover and reflect on each section which are displayed below. Once the inputs are complete, the doctor

completes a checklist which acts a prompt to ensure that they have considered the various aspects for their appraisal. An example of the checklist can also be seen below. The form is then submitted to appraiser ahead of appraisal meeting.

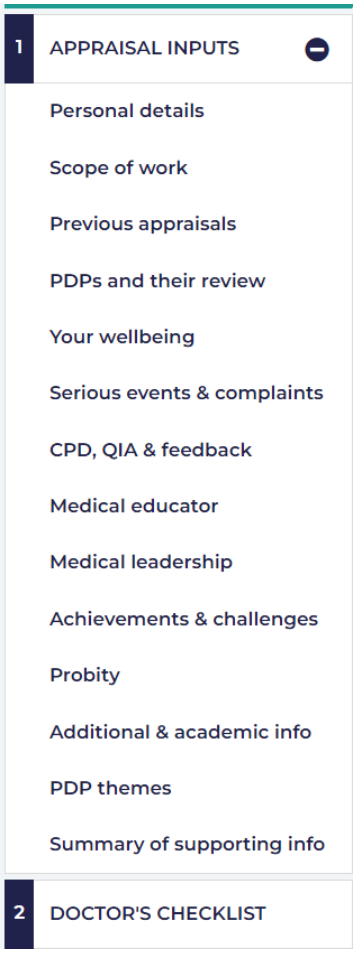


Figure 1 Sections of appraisal inputs

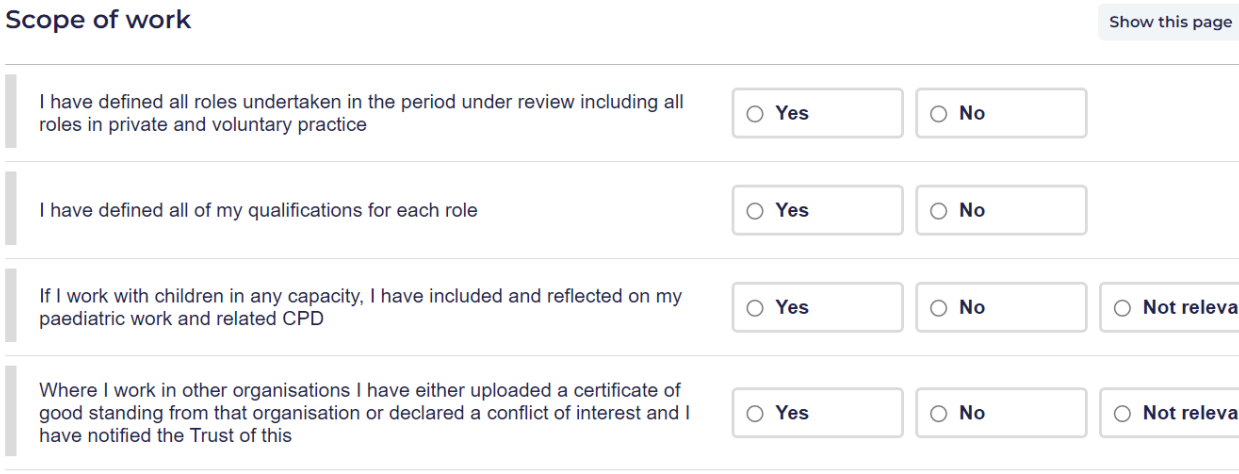


Figure 2 Excerpt of the doctor checklist

2. Appraisal meeting – meeting between doctor and assigned appraiser. This is where the confidential discussion will take place, verbal reflection, and discussions around wellbeing, professional development, and quality improvement.

3. Appraisal outputs – Doctor and appraiser agree a Personal Development Plan for the year going forward and the appraiser writes up a summary on how the doctor meets the four domains of Good Medical Practice, an overview of reflective discussions and quality improvements identified, with the supporting evidence provided. The appraiser then confirms five statements as detailed below. The appraiser and doctor both sign off the appraisal. The appraiser then completes their own checklist, as detailed below, submits to the Responsible Officer office for completion.

Figure 3 appraisal output sections

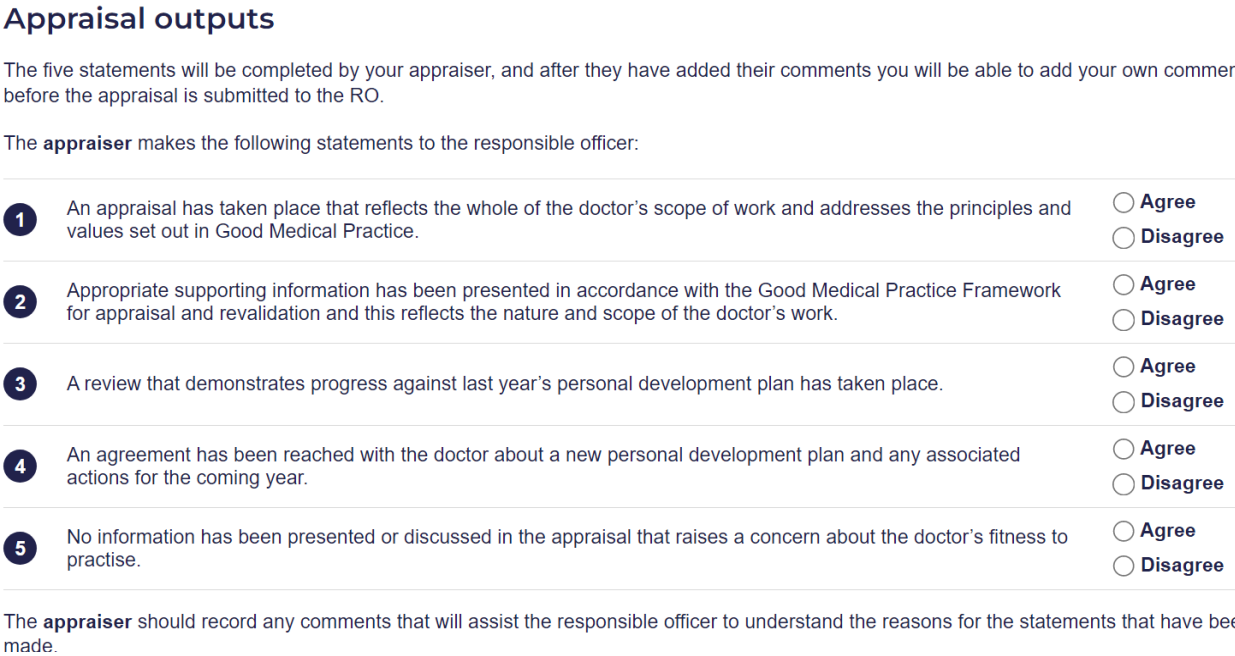


Figure 4 Appraisal output statements which require accurate completion by appraiser.

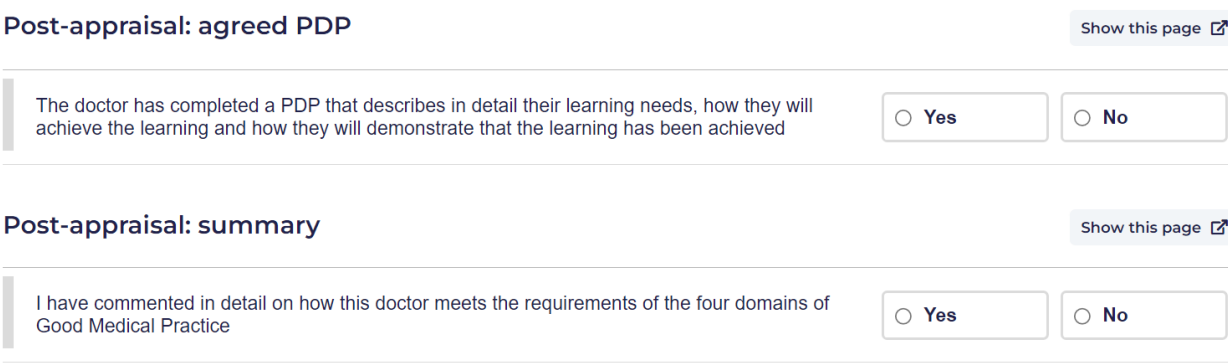


Figure 5 appraiser checklist

The appraiser is not automatically obliged to confirm all the statements as seen above if they feel that one or more is not reflected in the appraisal.

All doctors at Northern Lincolnshire and Goole NHS Foundation Trust are reminded that their annual appraisal must cover their entire scope of practice, which may include charity work, private work etc. and the doctor must provide evidence that they are fit to practice every single role they carry out whether this be clinical, managerial or educational because every single role a doctor carries out in their practice, does have an impact on patient care.

Supporting information to demonstrate fitness to practice against a scope of work does vary significantly as no doctor is the same as the other. However, supporting information is absolutely expected content for example, clinical governance information and its reflection.

As part of the support infrastructure, the coordinator has an established process for collection of clinical governance and supplying that information to doctors who are due for appraisal. This is a very efficient and seamless process, and the coordinator has shared best practice with other neighbouring organisations. It includes:

- Incidents that they have been named in the past 12 months; if a doctor is named in a significant event or incident, they must summarise the event and demonstrate reflective practice. Any doctors that are informed of a significant event/never event/SI, but upon Responsible Officer review the information is not included in appraisal, the appraisal will be referred back to the doctor to rectify.

- Formal Complaints that they have been named in the past 12 months.

Other expected content is patient and colleague feedback which must be done once every 5 years, in line with revalidation. Patient and colleague feedback module is installed on the L2P system. Upon receiving results of the feedback data, doctors are required to reflect on the results.

Doctors are encouraged to upload or provide evidence of medical indemnity/insurance. Where this is omitted, doctors are required to confirm that they understand the legal obligations on having medical indemnity/insurance for their role(s) and ensure that they are covered. The coordinator has produced a leaflet on medical indemnity which is installed on the L2P system and copies can be provided on an individual basis by the coordinator.

In relation to mandatory training, it is not a mandatory requirement for appraisal and/or revalidation. Compliance with mandatory training is overseen by a separate policy however continued significant failure to comply with mandatory training may prevent a doctor from revalidating, depending on the context and severity of the case.

To encourage improved compliance, the Revalidation Coordinator and Appraisal Lead have communicated to doctors that mandatory training courses do attract Continuing Professional Development points if there can be reflection on the learning. This is an accepted practice at Northern Lincolnshire and Goole NHS Foundation Trust.

All supporting information which is presented by the doctor must be fully reflected on how they meet the four domains of Good Medical Practice. Reflective practice also drives quality improvements as well as professional and personal development.

All doctors are contractually and professionally obliged to engage with appraisal. Doctors are sent reminders of sue appraisals via the L2P system and the Responsible Officer's office. Doctors who are late with appraisal are offered supported by the Responsible Officer office and the Associate Medical Director.

Consistent non-engagement with appraisal, despite efforts from the Responsible Officer team and the Associate Medical Director, results in the Responsible Officer discussing the doctor's individual case with the General Medical Council Employment Liaison Advisor. The General Medical Council will issue an early warning to the doctor requiring the doctor to engage by a deadline. If this deadline is not met, the doctor is referred to the General Medical Council for non–engagement.

No submissions of non-engagement have been made during 2023-2024.

3.2 Medical Appraisers

Between April 2023 and March 2024, Northern Lincolnshire and Goole NHS Foundation Trust had 55 trained appraisers, which also includes 6 senior appraisers. The appraisers are allocated 0.25 Programmed Activity per week and can be allocated a maximum of 10 doctors to appraise. The budget for medical appraiser role has been moved from the operational divisions and now is within the Chief Medical Officer's directorate. The coordinator and appraisal lead oversee recruitment of appraisers.

Each Medical appraiser undergoes quality reviews. This consists of two parts; A report which collates appraisee's feedback via the post-appraisal questionnaire (PAQ). An example of Post Appraisal Questionnaire can be referred to in section 4.2.2. This report is sent to every appraiser to reflect upon and identify improvements where needed which increases the quality of appraisals and improves the process for doctors.

Secondly, a quality assurance report on the medical appraisal outputs that the appraisers have produced over a set time using 'EXCELLENCE' audit tool. The audit is completed by the coordinator with appraisal lead oversight.

The Coordinator and Appraisal lead use the final audit results to identify and implement improvement to local process which is then picked up in the annual training sessions.

We are now moving to position where consistent low performing appraisers are encouraged to retrain, and if no is improvement shown or there is unwillingness to participate in remediation of appraiser skills, those appraisers will be asked to leave the role based on performance. To do this an exit strategy will be created.

To formulate an exit strategy, a standard of procedure will be devised and agreed with relevant stakeholders and the creation of a new audit tool being led by the Clinical Lead for Appraisal, which will replace the EXCELLENCE form.

3.2.1 External Quality Assurance of Medical Appraisal Process by MIAD Healthcare LTD.

In June 2022, the Responsible Officer wished to establish a clear overview of all aspects of Medical Appraisal and Revalidation within the Trust and Miad Healthcare was commissioned to conduct an external review of the appraisal and revalidation system in Northern Lincolnshire and Goole NHS Trust Miad Healthcare is an external organisation with knowledge of revalidation and skills to assess systems and processes to provide support and make recommendations in line with NHS England Core Revalidation Standards, 2014.

The purpose of the external review:

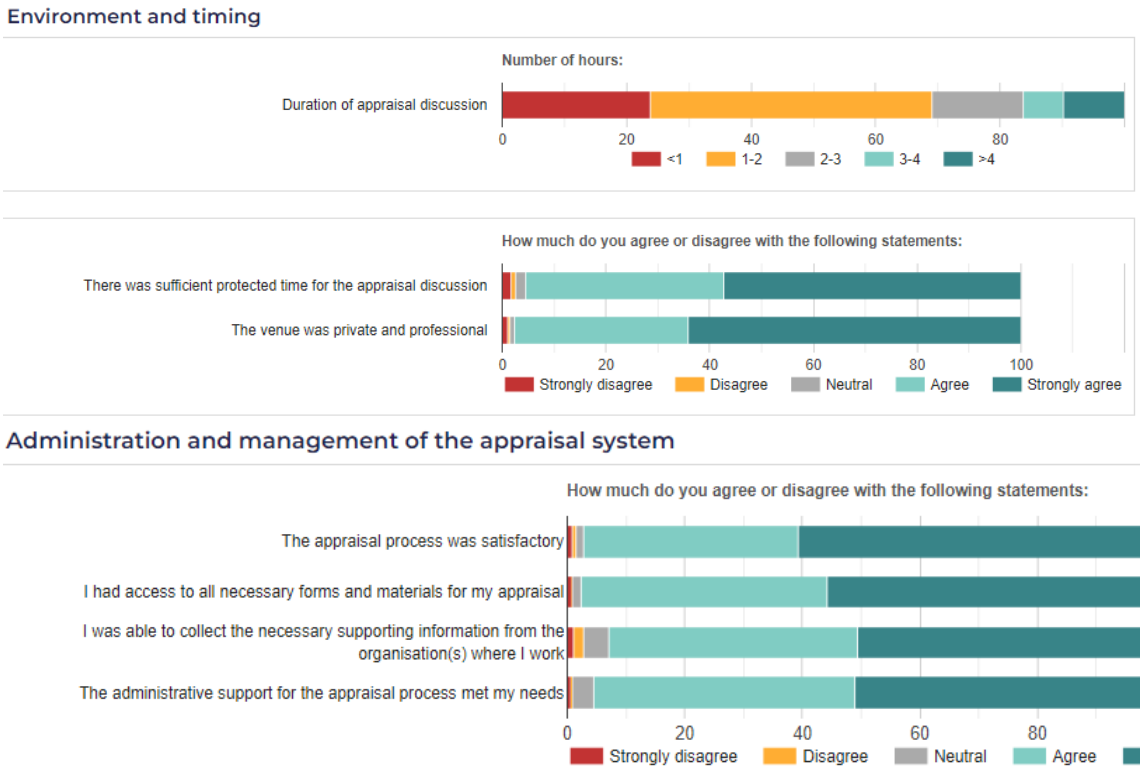
- To provide a benchmark and basis on which to further enhance the quality of appraisal and revalidation processes at Northern Lincolnshire & Goole NHS Foundation Trust
- To provide signposts to further develop the infrastructure to support revalidation and appraisal.
- To provide steers to strengthen links with Clinical Governance
- To provide feedback and recommendations

As a result of this review which, an action plan was agreed between MIAD and NLaG in March 2023. The action plan was completed in January 2024. The completed action plan is appended to this report.

3.2.2 Medical Appraisal Post Appraisal Questionnaire (PAQ) result

There were 349 responses submitted between April 2023 and March 2024

Process Overview



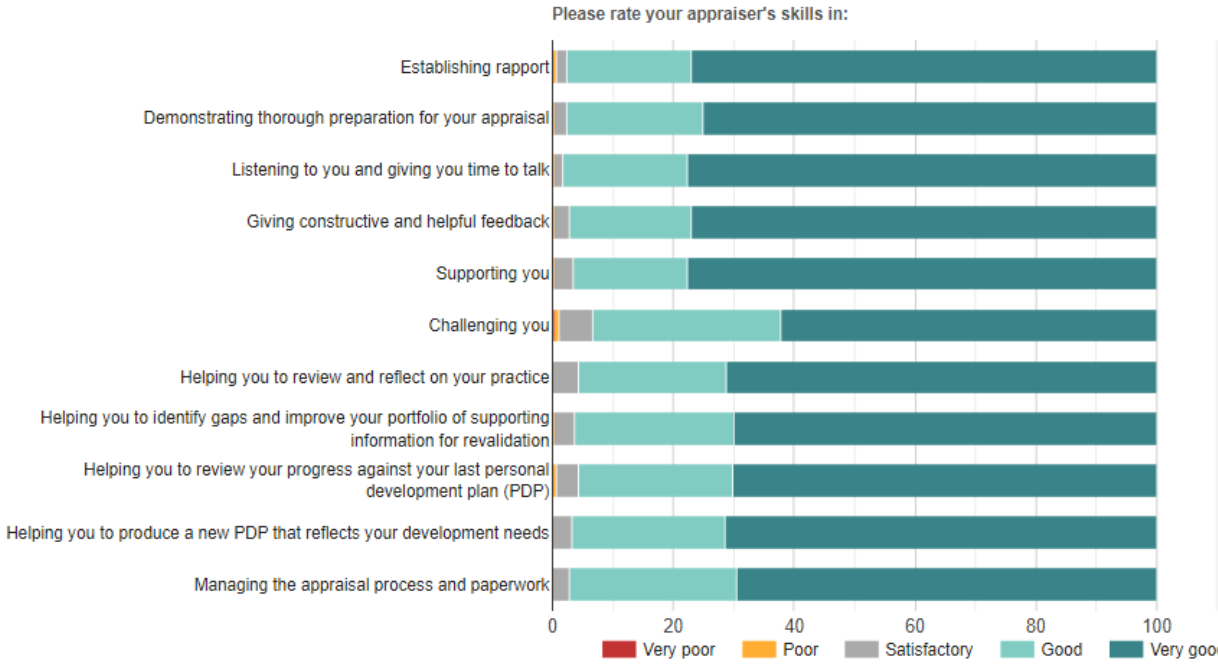
The headline feedback from doctors for 'Process Overview'

- Appraisal meetings typically last up 2 hours however emphasis is on ensuring that meetings are meaningful regardless of length.
- 95% of doctors agreed that they had protected sufficient time to complete their appraisal.
- 98% of doctors agreed that the venue was private and professional.
- 97% of doctors agreed that the appraisal process was satisfactory.
- 98% of doctors had access to all necessary forms and materials for my appraisal.
- 93% of doctors were able to collect the necessary supporting information from the organisation where I work.
- Ninety-five percent of doctors agreed that the administrative support for the appraisal process met their needs.

Appraiser Overview

Your appraiser

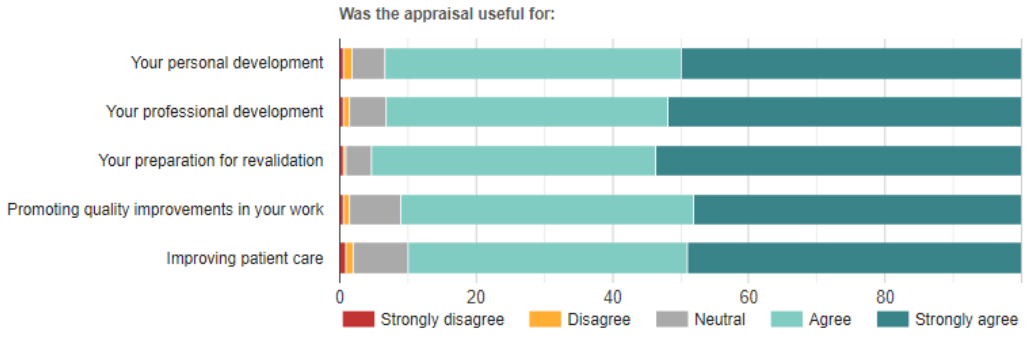
Please give your appraiser feedback for their personal development



Please rate your appraiser's skills in:	Very poor	Poor	Satisfactory	Good	Very good
Establishing rapport *	0%	1%	2%	21%	77%
Demonstrating thorough preparation for your appraisal *	0%	0%	2%	23%	75%
Listening to you and giving you time to talk *	0%	0%	1%	21%	78%
Giving constructive and helpful feedback *	0%	0%	3%	20%	77%
Supporting you *	0%	0%	3%	19%	78%
Challenging you *	0%	1%	5%	31%	62%
Helping you to review and reflect on your practice *	0%	0%	4%	24%	71%
Helping you to identify gaps and improve your portfolio of supporting information for revalidation *	0%	0%	3%	26%	70%
Helping you to review your progress against your last personal development plan (PDP) *	0%	1%	4%	26%	70%
Helping you to produce a new PDP that reflects your development needs *	0%	0%	3%	26%	71%
Managing the appraisal process and paperwork *	0%	0%	3%	28%	70%

Appraisal Overall

The appraisal overall



Was the appraisal useful for:	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Average
Your personal development *	1%	1%	5%	44%	50%	4.41
Your professional development *	1%	1%	5%	41%	52%	4.43
Your preparation for revalidation *	1%	0%	4%	42%	54%	4.48
Promoting quality improvements in your work *	1%	1%	7%	43%	48%	4.37
Improving patient care *	1%	1%	8%	41%	49%	4.36

3.3 L2P appraisal software

The Trust procured L2P in November 2021. All medical appraisal documentation is stored electronically on the system and only the coordinator has full administration rights. The coordinator only accesses and views full appraisal documentation when it is appropriate and reasonable of which this is set out in the Access Statement in the Medical Appraisal Procedure policy document.

Access and use of data adhere to the requirements of the Data Protection Act (1998). L2P is registered with the Information Commissioner's Office: Registration number. z2384214

If external individuals require a copy of a doctor's appraisal, then the requester must approach the doctor for written consent that the appraisal can be shared. The request must be reasonable and clearly stated.
On rare occasions this may not be possible particularly in police, legal or General Medical Council matters whereby appraisal information can be released without consent depending on the severity of the issue and what level of patient harm has occurred. These cases should they arise are judged case by case in relation to releasing appraisal information and in line with internal Trust polices.

There are clear guidelines regarding access arrangements for medical appraisal documentation for medical staff in the Medical Appraisal Procedure.

With regards to maintaining patient confidentiality, doctors are notified that supporting information that has patient identifiable data must be removed or redacted before uploading documents to the L2P form. They are required to tick a confirmation every time they upload evidence.

For the Board's information there have been no breaches of patient data or staff data in relation to medical appraisal documentation to date in during 2024-2024.

L2P has several reporting mechanisms. This includes.

- NHS England quarterly compliance
- NHS England annual compliance
- Past appraisal performance by grade
- Past appraisal performance by department
- Resource forecast by month
- Resource forecast by department
- Late appraisals by department
- Late appraisals by month
- Appraiser activity

- Appraisals with appraiser
- Appraisal completion by department
- Agreed Personal Development Plans learning/development needs.
- Medical educators
- Medical educators Continuing Professional Development
- Medical Leadership

The contract with L2P is due to expire in November 2026.

3.4 Quality Assurance measures

Current quality assurance processes and measures are outlined below:

- Appraisee feedback on the overall process and their appraiser.

- EXCELLENCE quality assurance tool. Every appraiser has two appraisals quality assured per appraisal year This equates to approximately one hundred appraisals being quality assured per year. The Clinical Lead for Appraisal and Revalidation and Medical Appraisal Coordinator completes this audit. The results of the audit are shared with the appraisers with individual profiles that highlight areas of strength and improvement.

- Monthly revalidation meetings between the coordinator and the Responsible Officer

- Responsible Officer occasionally facilitates at the Responsible Officer network meetings, in partnership with NHS England and the General Medical Council. This ensures sharing of best practice and new process development.

- Annual Training events for medical appraisers and all medical staff who wish to learn more about local process.

- Annual revalidation report

- Statement of compliance signed by the Chief Executive Officer, which is then submitted to NHS England

3.5 Appraisal Data

3.5.1 Annual Organisational Audit report (AOA)

The Annual Organisational Audit report is an element of the Framework of Quality Assurance (FQA), and this is a standardised reporting mechanism for all Responsible Officers (Responsible Officer) to complete and return to their higher-level Responsible Officer.

Name of organisation: Northern Lincolnshire and Goole NHS Trust	Consultants	Specialty Doctors, Associate Specialists, Specialists (SAS)	Temporary contact holders (all fixed term contract holders)	Trustwide
Total number of doctors with a prescribed connection as of 31 March 2023	174	203	111	488
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	169	124	96	389
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	5	79	15	99
Total number of agreed exceptions	5	79	15	99

The headline results for the above is that there are no doctors who did not have an appraisal without an agreed exception/mitigating circumstance.

As a team, the Revalidation Coordinator and Appraisal Lead engage with and continually stay in contact with clinicians who may be experiencing delays to their appraisal. This means providing bespoke 1:1 support, guidance, and understanding for those who are experiencing difficulties, whether personally or professionally, which may cause delays to appraisal.

This approach, a combination of a resolute support team and electronic document management system is the primary driver for the above results which are a Northern Lincolnshire and Goole NHS Foundation Trust first.

As a result of the above Annual Organisational Audit results, Northern Lincolnshire and Goole NHS Foundation Trust can demonstrate not only standard compliance with regulations relating to the Medical Profession and other key pieces of legislation (Medical Act 1983) and key national guidance (Good Medical Practice for example), but that the journey of continued improvement over time is a successful endeavour. The results above will allow Northern Lincolnshire and Goole NHS Foundation Trust to continue in its pursuit of quality improvement for the medical appraisal process and its services provided by the Trust, provide necessary assurance to the higher-level Responsible Officer of NHS England and function as evidence Care Quality Commission inspections.

A breakdown of the exceptions granted is as follows:

- Three doctors had long term sickness during their appraisal.

- One on maternity leave/adoption leave

- Two on “other leave” (long term caring responsibilities, compassionate, personal/family reasons).

Those above are being continually supported 1:1 and continue to have access to the relevant resources to complete their appraisal.

- Ninety-three doctors were new arrivals to the UK and the NHS and obtained their primary medical qualification outside the UK. Last year this was eighty-five.

  New doctors to the UK and NHS do have a delay to their first appraisal which range up to 12 months from their start date. The reason for this is because a doctor has to bring a significant amount of supporting information and evidence which matches their scope of work, demonstrates that they are safe, demonstrates engagement with professional standards, demonstrates continued improvement within their service area (e.g., participating in audits) and ultimately the supporting information and the discussions around it will contribute to lifelong professional development.

  Furthermore, appraisal is the now the vehicle of reflective practice, and this is usually a new key skill that doctors new to UK practice must learn in preparation for appraisal. Reflective practice is a skill that continually evolves through the career of a clinician so therefore new starters to the trust are given ample time to not only settle into their new life in the UK, and the challenges and tasks that entails, but to acquire the soft skills required for their role, such as the ability to reflect, develop communication skills, as well as obtaining the necessary evidence to reflect on (such as feedback and CPD certification).

  These doctors are engaged by the coordinator to have a 1:1 medical appraisal support session which aims to induct the doctors into the medical appraisal process and therefore can begin work on their portfolio which constitutes as process engagement.

3.5.3 Medical and Dental Staff Appraisal Compliance

Since 1st July 2022, the coordinator submits weekly data to the Workforce Intelligence and Systems which is then uploaded to Workforce Information systems on Power Business Intelligence.

The same data is also submitted to the Human Resource business partners for the Performance Review and Improvement meetings, and this ensures reporting consistency.

	PADR Rate	Feb 2024	85.0%	85.0%				Board
	Medical Staff PADR Rate	Feb 2024	96.5%	85.0%				Board
Staff Development	Combined AfC and Medical Staff PADR Rate	Feb 2024	85.7%	85.0%	Highlight			Board

Figure 6 excerpt from workforce IPR scorecard (web capture date: 04/04/2024)

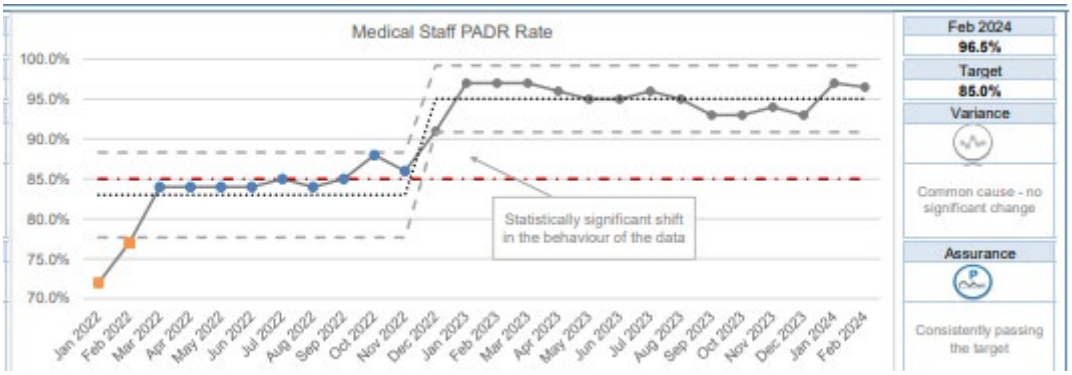


Figure 7 SPC chart medical PADR compliance (web capture date: 04/04/2024)

The positive Annual Organisational Audits results are shown above are also reflected by the Trust's internal reporting systems as demonstrated in the Integrated Performance Reporting Workforce report.

4. Recommendations of Revalidation to the General Medical Council

4.1 Revalidation submission data

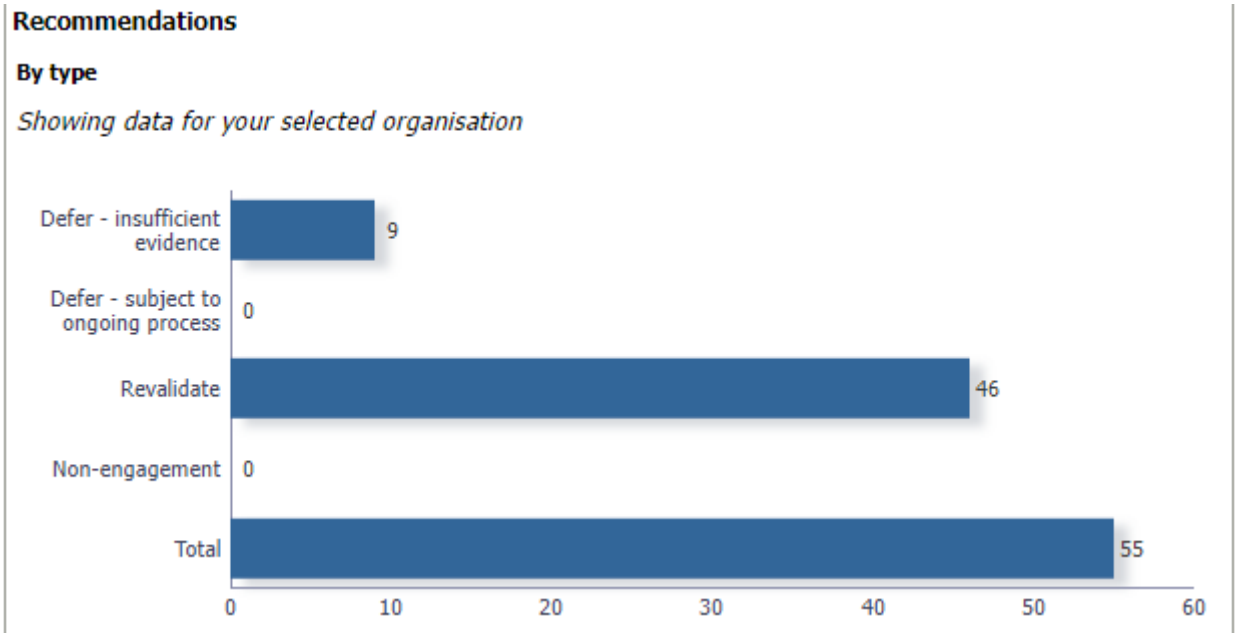


Figure 8 Data from General Medical Council Connect Northern Lincolnshire and Goole NHS Foundation Trust Dashboard

Between 1st April 2023 and 31st March 2024, 46 doctors were revalidated. A doctor revalidates once every 5 years. There were no non -engagement submissions made to the General Medical Council by Northern Lincolnshire and Goole NHS Foundation Trust.

There were nine deferrals. It is important to note that deferral does not mean that a doctor has failed to revalidate.

Deferring is a neutral act which grants a time extension for the doctor to complete the necessary requirements to be revalidated – annual appraisals and 360 feedback completed in the last 5 years. The nine deferrals outlined above were all made because the doctors had insufficient evidence – primarily this was due to the lack of completion of 360 feedback from colleagues and patients with a reflective piece of work on the feedback results.

5 Medical Governance

5.1 Local Medical Governance arrangements for medical appraisal

The Responsible Officer for the period 1st April 2023 – 31st March 2024 (Dr Kate Wood, Chief Medical Officer) was appointed by the Trust Board in 2018 in line with statutory requirements. The Chief Medical Officer is supported by the Clinical Lead for Appraisal and a band 5 Coordinator who manage 480 doctors to engage with processes that underpin revalidation.

Progress and compliance with the regulations is monitored by:

- A well-established Recommendation of Revalidation procedure, in line with GMC guidance, whereby all revalidation decisions are recorded and stored in the relevant Chief Medical Officer files on the H Drive.

- Weekly compliance data to Workforce Information System team (Integrated Performance Reporting) and to the Human Resource business partners for Performance Review and Improvement Meetings within the divisions.

- Submission of the Annual Organisation Audit report to NHS England's Higher-Level Responsible Officer.

- Comprehensive dashboards within L2P to access and review data.

- Formal audits using EXCELLENCE once a year. The audit methodology is currently being reviewed.

5.2 Monitoring conduct and performance.

Medical staff performance and conduct is managed through regular supervision, through annual appraisal and participating in regular audits, case reviews, Structured Judgment Reviews, all but to name a few, as part of quality improvements processes which are captured via the medical appraisal.

During appraisal discussions the doctor is encouraged to discuss aspirations and challenges and to review the progress of Personal Development Plan objectives. The doctor is also required to reflect meaningfully on when things have gone wrong and demonstrate how changes and learning needs have been identified and actioned.
We also train appraisers to challenge doctors in relation to participating in quality improvement activities, especially if there is a deficiency in this area.

Separately, the “Doctor’s in Difficulty” (DiD) group has been operational since April 2018. The purpose of the Doctors in Difficulty group is to ensure those required to attend are sighted on issues and concerns in relation to “Doctors in Difficulty.” Doctors are classified as being in difficulty if they meet one or more of the criteria below.

- Known through internal referrals to/from the General Medical Council and NHS Resolution and/or have restrictions on clinical practice.
- Going through a Maintaining High Professional Standards investigations
- On or recently returned from long term sickness absence
- Recent sickness absence relating to stress, anxiety and/or other mental health issues.
- Have had 4+ sickness episodes in over 12 months (rolling)
- Involved in a confirmed serious incident.
- Training issues
- “Other” – this covers a range of issues that would not sit in the above categories, for example, employment tribunals.

The attendees of the group, which has senior Human Resource representation, gives an opportunity to check whether the doctors mentioned above are receiving the required support from the operational divisions and the Human Resource Business Partners, and challenge where there is a deficiency in pastoral support and/or general support altogether (such as return to work).

Additional advice is sought from the Practitioner Performance Advice Service (part of NHS Resolution) as soon as a grave concern arises. The General Medical Council’s employer liaison adviser is contacted as appropriate. Any grave concern is registered with the Chief Executive, Chief Medical Officer and Director of People and Organisational Development.

5.3 Responding to Concerns

The Trust has a specific Maintaining High Professional Standards Policy/Procedure (MHPS) which supports in dealing with responding to concerns. In addition, the Doctors in Difficulty Group ensure those required are sighted on issues and concerns known through recruitment of doctors with restrictions on their practice, internal referrals to/from the General Medical Council and NHS Resolution or those that have previously or are due to commence employment at Northern Lincolnshire and Goole NHS Foundation Trust

.

Our Trust Board is sighted on all cases going through the formal Maintaining High Professional Standards process, for example the number of suspensions and this is provided by the People Directorate.

5.4 Transfer of Information between Responsible Officers

When a doctor joins Northern Lincolnshire and Goole NHS Foundation Trust and has come from another UK healthcare organisation whether this is another NHS Trust, Locum agency or training, then the coordinator invokes the Medical Practice Information Transfer process (MPIT).

The coordinator will formally contact the doctor's previous designated body with a Medical Practice Information Transfer form, which is prepopulated with the doctor's name, General Medical Council number and Northern Lincolnshire and Goole NHS Foundation Trust 's Responsible Officer details, and requests that the designated body and its Responsible Officer, or authorised delegate, fills in the form.

The Medical Practice Information Transfer form requests the following information.

- Date when Doctor left previous organisation.
- Date of last Annual Review of Competencies Panel OR appraisal
- To inform the new Responsible Officer any of additional information or concerns relating to the doctor's practice

Occasionally, a doctor's previous Responsible Officer requests to have a conversation with the Responsible Officer of Northern Lincolnshire and Goole NHS Foundation Trust and this is swiftly organised.

If information of note is shared with the Responsible Officer of Northern Lincolnshire and Goole NHS Foundation Trust regarding a doctor's practice, there is collaboration between the Responsible Officer , Associate Director of Strategic Medical Workforce, Divisional Medical Directors, and the Clinical Lead for the employing specialty, to support and if necessary, supervise the new doctor.

6. Employment checks

Systems to ensure that appropriate pre-employment background checks are undertaken to confirm doctors who are starting with the Trust, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties, are covered by the Recruitment and Selection Policy and the "Recruitment and Selection – A Best Practice Guide."

For Agency Locum doctors who are identified as potential candidates to fill a shift which is live on the Locum Management System, the CV of a potential candidate is sent to the Clinical Leads to review that the qualification, skills, and training competencies of the candidate are suitable for the shift.

7. Conclusion

7.1 Review of actions from last year's annual revalidation report

MIAD Action Plan

Complete actions on the MIAD action plan by December 31st, 2023. Action Plan is appended with this report in separate bundle (*Annual Revalidation Report Appendix 1 – MIAD action plan)* The action plan has been completed.

Annual Revalidation Report Appendix 1 – MIAD Action Plan

Increase in number of doctors connecting to Northern Lincolnshire and Goole NHS Foundation Trust

The number of doctors connected to Northern Lincolnshire and Goole NHS Foundation Trust has increased annually every year since 2014. To highlight, there are 176.40wte more medical posts in the trust in November 2023 vs April 2019 and the medical appraiser budget has remained static.

This increases number of resources required to ensure all doctors can engage and comply with appraisal and revalidation which requires adequate number of appraisers.

A business case has been submitted to acquire additional funds to recruit more appraisers.

General Medical Council becoming multi-professional regulator

Anaesthesia Associate and Physician Associate will come under regulation of the General Medical Council and will be required to revalidate. The GMC have stated that revalidation for PAs and AAs will be implemented after the two-year regulation transition period which will begin when regulation of PAs and AAs will start (December 2024). This means that revalidation will start no sooner than December 2026 for PAs and AAs.

Further guidance will be disseminated by the GMC, but it is expected that revalidation will be the same for PAs and AAs as it is for doctors.

Good Medical Practice update

Good Medical Practice has been updated and has been implemented since January 30th, 2024.
Updates to the appraisal form have been implemented to reflect the new guidance and its themes and domains.

Widening Professional Behaviours and Patient Safety workshop

Workshops have been arranged with the GMC to deliver the above workshop. Other GMC courses have been arranged and will be running until September 2024.

Medical Appraisal Procedure document review

Ratified policy document has been approved in July 2023 and is due for review July 2026.

7.2 Current issues and new actions

Progression of Business Case

The business case for increase in medical appraisers was submitted in January 2024. However, due to the implementation of the new care group structure and the restructure of all other relevant departments to this the business case has been placed on hold until such time this can be submitted for approval.

7.3 Action from the Board

To ask the Board to accept the report, noting it will be shared with the higher-level Responsible Officer at NHS England and Improvement.

The Board, through the Chief Executive, are required to sign the 'Statement of Compliance' at the end of the report confirming that the organisation is compliant with the Responsible Officer regulations.

The approved annual report and signed statement of compliance will be submitted to NHS England by the Responsible Officer's office.

Feedback and recommendations from the Board are also welcomed.

8. Statement of compliance

The Board of Northern Lincolnshire and Goole NHS Foundation Trust have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body:

Chief Executive Officer

Official name of designated body:
Northern Lincolnshire and Goole NHS Foundation Trust

Name: **Signed:**

Role:

Date:

	Recommendation (What are the key learning points / what changes need to be made)	Action to be Taken (How the changes will be made)	Risk	Lead & Oversight (For ensuring each action happens)	Timescale for Completion / Date Completed	Evidence of Completion (sources of verification)	Progress notes	RAG Status
1. Appraisees Scope of Practice								
a)	There needs to be greater clarity around hours or sessions worked in each role contained within the scope of practice.	- Provide guidance for all doctors on scope of work from Royal colleges, GMC and NHS England. - Incorporate in appraiser training - Incorporate into the personal 1:1 appraisal support session - Liaise with L2P regarding potential developments	Low	**Rachael Norfolk and Ajay Chawla**	**December 31st 2023**	Established guidance disseminated to all medical staff (i.e. Hub page) Programme agenda for appraiser training L2P updates	Scope of work is discussed at 1:1 medical appraisal support sessions. Rachael Norfolk advises doctor to ensure all roles are covered. Clarified that private work isn't just private healthcare work, may also include work for charity or any other non-nhs work that requires a licence. **This topic was also discussed at the appraiser network on 5/5/2023.**	

b)	SAS and Consultants to upload Job Plan to the appraisal as supporting information	- include in newsletter/comms - Include in appraiser training - Include in personal 1:1 support session * encourage uploading of job plan but be clear that this not mandatory	Low	**Rachael Norfolk/Ajay Chawla**	**December 31st 2023**	**Job plans uploaded to appraisal – audit would be required to confirm if this is being done.**	**This was discussed and covered at the appraiser network (5/5/2023) and is highlighted at 1:1 appraisal support session (for new starters)** **Included in summer newsletter.**	
c)	Doctors who do private/non-NHS work (such as private hospitals, charity roles, or any other role outside main employment that requires a licence) to include a letter of good standing from other place of work	- include in newsletter/comms - Include in appraiser training - Include in personal 1:1 support session - NLaG RO/CMO to write to all local private providers that this is usual part of the appraisal process, and are they ok to provide this in a timely manner when requested.	Low	**Rachael Norfolk/Ajay Chawla**	**December 31st 2023**	**Scope of work covered in the appraiser training programme.** **In 1:1 support session, there are discussions about the importance in ensuring CPD matches full**	**25/04/2023 – this topic has been placed on agenda for next NLaG appraiser network (5/5/2023)** **Letter ready to be sent, waiting on contact list for local private providers** **RN has contacted PP team to ascertain a list**	

		- Draft letter for doctors to send through to their private employers				**range of practice.** **Consider audit and reaudit to see if changes are effective**	**of PP work doctors to begin audit.,**	
2. Appraisees Supporting Information (evidence uploaded to appraisal form)								
a)	Appraisees need to be reminded of the important of maintaining anonymity for patients and colleagues as described in the GMC document "*Guidance on Support information for appraisal and revalidation"*	- include in newsletter/comms - Include in appraiser training - Include in personal 1:1 support session - Liaise with L2P	Breech of confidential information.	**Rachael Norfolk/Ajay Chawla**	**December 31st 2023**	**No patient identifiable information is identified by appraiser or RO office at point of sign off.**	**Doctors are required to confirm, with every piece of supporting information uploaded, that there is no patient identifiable information.** **Included in May Newsletter** **Discussed at Appraisal Network (5/5/2023)**	
3. Appraisees Continuing Professional Development (CPD)								

a)	Some portfolios give the impression of more than enough CPD but the number of CPD points are not inputted.	- include in newsletter/comms - Include in appraiser training - Include in personal 1:1 support session - Liaise with L2P to see if the inclusion of CPD points more prominent/mandatory input within form can be.	Low	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**No appraisal will have 0 CPD points**	**In 1:1 support session, doctors are routinely informed of the importance of inputting CPD points.** **When doctors upload evidence, there are boxes at the bottom to input CPD points** **Discussed at appraiser network 5/5/2023 – general agreement that the reflection on the CPD undertaken is more important than the points however point allocation will be encouraged.** **Appraiser handbook developed and published.,**	

b)	Where the above occurs, appraisers include in their summary notes that omission of CPD points is an error.	-appraiser training -include in appraiser networks - L2P system allows for referring back where 0 CPD points inputted -	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**No appraisal will have 0 points.**	**The GMC now emphasise quality CPD over quantity ~(i.e they do not mandate a minimum requirement)** **25/04/2023 – this topic has been placed on agenda for next NLaG appraiser network (5/5/2023)**	
4. Appraises Quality Improvement Activity (QIA)								
a)	There is a range of QIA evidence. Academy of Medical Royal College (AMRC) guidance to be shared with appraisees so they are aware of full range of options	- Develop dedicated QIA guidance in step with AMRC guidance and disseminate to all doctors - Liaise with QI team	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**Established guidance disseminated to all staff.**	**Appraiser handbook in development which will cover QIA.** **Once complete, all staff guidance which will be uploaded onto L2P resources and hub page.** **The L2P resources tab has links to the Royal**	

							college's appraisal web pages	
5.	**Appraisees Significant Events (SE's)**							
a)	Appraisees who are informed that there are no incidents attached to their name, should take opportunity to learn from incidents that have occurred in their areas of work. This is an opportunity to be pro-active in their practice as described in the Patient Safety Strategy 2019 guidance.	-Work with L2P to emphasise this point – this would go in the QIA section – this could be something that AMRC also advises in their QIA guidance. - developing local comms/guidance	Low	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**Increase in number of 'periphery' incidents/events included in appraisal**	**Discussed at appraiser network 05/05/2023.** **Topic is being covered in the newly developed appraiser handbook.** **Included in May newsletter** **When doctors receive emails from CMO office regarding clinical gov info, they are encouraged to include incidents/events that they are aware of and can learn from.**	

6.	**Appraisee Colleague and Patient Feedback (MSF/360 feedback)**							
a)	Encourage the collection and inclusion of informal feedback which is reflected upon for those years of the cycle that do not include MSF/360. This is a GMC recommendation	- **Comms via newsletter** - **Via appraiser networks** - **Via 1:1 support session**	Low	**Rachael Norfolk /Ajay Chawla**	**December 31st 2023**	**Increase of informal feedback in appraisal**	**Discussed at appraiser network** **Covered in Mays Newsletter** **Included in appraiser handbook**	
7.	**Appraisee Complaints and Claims**							
a)	Appraises who declare non-involvement in complaints should take opportunity to review complaints that have occurred in their area of work. This will need reflection and description of changes to practice for quality improvement purposes and learning outcomes.	-Work with L2P to emphasise this point – this would go in the QIA section – this could be something that AMRC also advises in their QIA guidance. developing local comms/guidance - appraiser training	Low	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**Increase in number of 'periphery' complaints included in appraisal**	**As above for incidents/SUIs**	

b)	Claims to be routinely included in appraisal which are then to be reflected upon by the appraisee and include any changes to practice as a result as identified in Patient Safety Strategy Guidance.	- Work with Gerard Curran's team to implement. - Use same process for complaints and SIs	Low	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**Claims included in appraisal**	**Rachael Norfolk currently liaising with Gerard Curran to establish process like that of the Incident and complaint sharing process** **25/04/2023 – still awaiting confirmation from GC that he has had conversation with Sarah Davy** **30/05/2023 – pending update from GC regarding this.** **August 2023 – Escalated to Senior Management Team via Oversight and Review meeting as no response.** **December 2023 – resolution being**	

							sought by SMT to get process implemented. The current system does not pull off specific reports around claims and to do this manually would involve a high level of resource. On further discussion it was agreed that any doctor who was involved in a claim would have been identified at the early stage of complaints and incidents. Claims are complex in that they may come in with a named doctor but this may either not get progressed or changed. It was agreed therefore not to	

							pursue this action further.	
8.	**Appraisee Reflective Practice**							
a)	Appraisees need to ensure that they complete reflective activity for each of the six (6) elements as set out in the AMRC 2022 Guidance.	-disseminate guidance to all doctors -encourage practice via appraiser networks and training Work with L2P consider software updates – i.e. Making the reflective text a mandatory requirement and the appraisal summary box mandatory requirement.	Low	**Rachael Norfolk /Ajay Chawla**	**December 31st 2023**	**Will need to do audit to see if there meaningful reflection**	**When doctors upload supporting information, they are prompted to reflect .** **05/05/2023 – discussed at appraiser network** **Appraiser handbook being developed.** **Appraisal team looking to implement reflective workshops.** **Appraiser handbook published and**	

							disseminated August 2023. **GMC sessions are being set up for 2024.** **Appraiser training for March 2024 being ser up.** **December 2023 audit complete. Actions identified to ensure successful implementation**	
9.	**Appraiser and Appraiser Infrastructure**							
a)	Appraisers to review guidance and training on the importance of summary statements and the detail required to provide assurance to the RO that all elements of the scope of work have been covered and challenged. The	- Develop guidance and disseminate to appraisers - Look at the appraiser training module on summary statements. - Appraiser networks	**medium**	**Rachael Norfolk / Ajay Chawla**	**August 31st 2023**	**Better quality output summaries as identified in 'Excellence' Audit.** **Dissemination of established guidance**	**RN producing 'Appraiser handbook' which will contain examples of high-quality summaries and producing a template which can be used**	

	summary statements should also demonstrate that support has been the focus of discussion.							
b)	To include in summary notes of any CPD discussed at appraisal meeting but not uploaded to the appraisal form by appraisee.	- Appraiser training - Consider software update on form on appraiser note section – “hints and tips”	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**Excellence audit will identify improvement of appraiser oversight of CPD**	**Discussed at appraiser network 05/05/2023** **Recent reaudit (August 2023) has shown improvement in CPD discussion summary**	
c)	Appraisers to ensure that all support information uploaded is anonymised (where relevant), particularly patient and colleague feedback.	- Via appraiser networks - L2P form already prompts doctor to check supporting information before upload (there is a mandatory tick box)	**Medium**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**No breeches of confidential information**	**Doctors are required to confirm, with every piece of supporting information uploaded, that there is no patient identifiable information.**	

d)	Fuller analysis and reference to lessons learned and changes to practice made as a result need to be documented by the appraiser in summary notes	- Encourage via appraiser training - Disseminate the "reflective practitioner" - Encourage via appraiser net work - - consider a "hints and tips" software update but this will need buy in from supplier	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**Excellence audit will reflect that appraiser summary encourages changes and improvements because of identified improvements**	**Development of appraiser handbook to help guide appraisers in developing summaries that take note of "lessons learned".**	
e)	Appraisers to bring clarity to the PDP discussion and document clearly what has been achieved, identify gaps and aspirations of the appraisee.	-liaise with L2P with appraiser hints and tips - appraiser training -comms via appraiser networks	**Low**	**Rachael Norfolk / Ajay Chawla**	**31st December 2023**	**EXCELLENCE audit will show improvement in PDP quality.**	**Appraiser handbook published** **This was discussed at NLAG appraiser network 05/05/2023**	
f)	Appraisers to encourage appraisees to consider other incidents/evens/complaints/outcomes/reviews in their own speciality	liaise with L2P with appraiser hints and tips - appraiser training -comms via appraiser networks	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**Increase in number of 'periphery' incidents/event**	**Appraiser handbook published** **This was discussed at NLAG appraiser network 05/05/2023**	

	practice to see if their areas of patient or staff safety which could be improved upon.					**s included in appraisal**		
g)	Appraisers need to use the appraisal discussion to further support appraisees to develop their PDP more fully, with a clear link to professional development needs and outcomes that benefit patients and provide documentary evidence that this has happened.	- liaise with L2P with appraiser hints and tips - appraiser training -comms via appraiser networks	**Low**	**Rachael Norfolk / Ajay Chawla**	**31ST December 2023**	**Increase in quality of PDPs as identified by EXCELLENCE audit.**	**Appraiser handbook published** **This was discussed at NLAG appraiser network 05/05/2023** **Appraiser training also covered the development of PDP in depth/**	
h)	Appraisers support appraisees with reflective practice during the appraisal discussion and document that this happened.	- liaise with L2P with appraiser hints and tips - appraiser training -comms via appraiser networks	**Low**	**Rachael Norfolk /Ajay Chawla**	**December 31st 2023**	**Will need to do audit to see if there meaningful reflection being discussed as evidenced in**	**When doctors upload supporting information, they are prompted to reflect.** **Appraiser handbook published**	

		- Disseminate AMRC "Facilitating ref lection A guide for supervisors"				**appraiser summary**	**This was discussed at NLAG appraiser network 05/05/2023** **Reflective practitioner uploaded to L2P resources page which can be accessed by all doctors**	
i)	Appraisers need to ensure comments and questions documented prior to appraisal discussion are updated prior to final submission	-appraiser training -comms via appraiser network - At RO sign off, refer back appraisals that have pre-meeting comments.	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**No pre-meeting comments/question will be in appraisal summary**	**Appraiser handbook published** **This was discussed at NLAG appraiser network 05/05/2023**	
j)	Statements and declarations need to accurately reflect both the input and the appraisal discussion	- appraiser training -comms via appraiser networks	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**EXCELLENCE audit will demonstrate that inputs and outputs are matched**	**Appraiser handbook published** **This was discussed at NLAG appraiser network 05/05/2023**	

k)	Development of Appraiser summary outputs guidance/examples to show a consistent approach to documenting the appraisal discussions, including reflection, challenge and support in line with AMRC Medical Appraisers Guide.	Produce guidance and examples for dissemination Considering adding this to the CMOD hub. Upload onto L2P resource section.	**Medium**	**Rachael Norfolk / Ajay Chawla**	**August 31st 2023**	**EXCELLENCE audit will show quality summary which reflect the discussion which include reflect challenge and support discussions.** **Established guidance disseminated.**	**producing 'Appraiser handbook' which will contain examples of high quality summaries and producing a template which can be used . Appraiser handbook is now published**	
l)	Consideration should be given to mapping whether those Appraisers with poor summaries have been provided with sufficient training. There are examples in the audit conducted that look more like a chat which may indicate that the	- RN and AC to deep dive into results (- Consider putting those appraisers onto 3rd party appraiser training.	**Medium .**	**Rachael Norfolk / Ajay Chawla**	**August 31sr 2023**	**Audit results of specific low scoring appraisers.** **Improved performance demonstrated**	**Doctors have attended 1:1 with Ajay for training.** **Will audit (planned for august) so measure improvement via the appraisal summaries.**	

	Appraiser is not up to the date with current process of appraisal and evidence needed for revalidation					**by Excellence audit**		
m)	Making summaries standalone with basics needed for the Responsible Officer included	- Look at revalidation requirements and consider incorporating this into the appraiser summary/checklist	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**EXCELLENCE audit**	**Appraiser handbook being developed which will include good examples of appraisal summaries. Appraiser handbook published**	
n)	PDP development – training on focusing the appraisee on why they are looking to do something, what is the learning need (which course/conference will help with that) and how will they know they have successfully developed this with more emphasis on outcome in their practice rather than just	- Create guidance on PDP development - Look at online webinars/workshops for dissemination (the Open University have this) - Comms via newsletter	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**EXCELLENCE audit will show increase in SMART PDP**	**Appraiser handbook published** **This was discussed at NLAG appraiser network 05/05/2023** **PDP module at appraiser training event**	

	certificates of attendance.							
o)	Review of the appraiser training programme to meet the recommendations set out in this action plan	Summarise recommendations for appraiser lead and senior appraisers to include in next training session	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**Renewed training programme**	**List of recommendations generated for training facilitators, awaiting meeting to update programme.** **25/04/2023 Training completed and feedback collated which is extremely positive**	
p)	Develop guidance in relation to Appraiser challenge within the appraisal discussion using shared example of high quality outputs.	- source examples of high-quality inputs for dissemination - incorporate a module around appraiser challenge into the	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**Excellence Audit.**	**Appraiser handbook published** **The challenging discussion was included at appraiser training**	

		training and network sessions						
12. Organisation- General Infrastructure								
a)	The appraisal checklists should be reviewed as they do not always match the documentation or 'not relevant' is picked when it is relevant without explanation.	- Will need to liaise with L2P regarding checklist as the appraisal form is updated to the new "shorter" version. - With the above considered, incorporate this recommendation into appraiser network sessions and training.	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**Summary discussions to reflect inputs which will be picked up via audit (Excellence or ASPAT)**	**Checklist is include in new appraisal format which act as useful prompt for doctors in case they omit any supporting information.**	
b)	Strive to fully engage in medical appraisal of some senior doctors, close to retirement.	- Would need to know which senior doctors are considering retirement as not all	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**Would need to specifically pick of those appraisals of doctors who are fully**	**Payroll confirmed that there is no process for capturing information on retiring doctors. However there is no issue with senior**	

		doctors fully retired (i.e retire and return)				**retiring to see what the engagement is like.**	**doctors not engaging with appraisal (as reflected in latest annual audit results submitted to NHSE)**	
c)	Include preparation for retirement in the appraisal discussion early to get doctors thinking about less clinical sessions and more education or management responsibility so that they can continue if they wish post-clinical retirement. Clear and consistent approach to ensure added value.	- Consider liaising with People directorate to see how this may be included in their retirement workshops - Look at any guidance regarding this recommendation and look to disseminate on CMOD hub and appraiser network	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**Would need to specifically pick of those appraisals of doctors who are fully retiring to see what the engagement is like.**	**As above. Senior doctors do engage with appraisal anyway. Incorporate into appraiser training small module on retiring doctors – i.e how to appraise those who are close to retirement, what kind of PDP should appraisers support for retiring doctors .**	
d)	Increase proportional representation across the Appraiser group to include all specialties.	- Would need to look at numbers across specialties however someone specialties have less than 5 doctors. Consider	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**Can provide information in annual report regarding**		

		proportional representation across the divisions as oppose to specialities.				**appraiser speciality.**		
e)	Consider lay presentation for the doctors in difficulty group	Consideration was given; however, this is not a formal meeting and just use of soft intelligence to ensure that the CMO has oversight particularly to ensure that the right support in terms of health and wellbeing is wrapped around the individual. Consideration will be given to a discussion with the CMO as to whether this should be put on a formal footing and if so a lay person would form part of the TOR.	**Low**	**Jane Heaton**	**Discussion with CMO before end of March 2023.**	**N/A**		
F)	Consider lay representation for the Revalidation meetings.	There is guidance on lay representation by AMRC and there is best practice which can be picked up from other organisations regarding	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**Lay representation at revalidation meeting**	**No Lay representation required at present. There is ongoing group restructure**	

		recruitment. Will need to develop a case for this						
G)	Re-establish the appraiser quarterly meetings and include topics covering GMC fitness to practice issues, support in sign posting well-being issue identified through the appraisal discussion, shared case studies and experience of difficult appraisals.	**These have been re-established. Considering covering the topics starting with next scheduled meeting.**	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**		**Meetings have been re-established**	
h)	Additional support provided Trust Grade/Career Grade doctors who can struggle to populate their portfolios with the correct supporting information. This group	Continue with 1:1 support session provided by CMOD. Continue with Welcome to UK Practice sessions at NLaG	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**Feedback from 1:1 session will highlight support is provided**	**Rachael Norfolk invites all new starters to a 1:1 session.** **GMC workshops upcoming in Feb, March and April.**	

	includes a high number of international medical graduates who have not got previous experience of medical appraisal and the knowledge base is not there.	Look at additional appraisal sessions aimed at international medical graduates.					**25/04/2023 – feedback Is being obtained from these 1:1 sessions which will be included in annual revalidation report and use for QI purposes.**	
i)	Guidelines around the development of a PDP, to ensure that sufficient detail and goals are included to know what outcome is expected and how the doctor can truly evidence the achievement of that goal	Produce guidance that can be disseminated Find examples of high quality PDPs for dissemination on CMOD hub, resource page on L2P and via appraiser training/network.	**Low.**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**Better quality PDPs as identified in EXCELLENCE audit**	**Appraiser handbook published** **This was discussed at NLAG appraiser network 05/05/2023** **PDP module included at appraiser training.**	

A framework of quality assurance for responsible officers and revalidation

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

RESPONSIBLE OFFICER REPORT 2023/24

Annex D – annual board report and statement of compliance

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020 but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board of **Hull University Teaching Hospitals NHS Trust** can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Yes – Mr Peter Sedman is the Trust's appropriately trained and appointed Responsible Officer for Hull University Teaching Hospitals NHS Trust and Dove House Hospice for 2023/24. Dr Ananthakrishnan Ananthasayanam will become the Group Responsible Officer for NHS Humber Health Partnership with effect from 1st July 2024

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Yes. This is held and maintained by the HUTH Revalidation Team.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Yes – the Revalidation & Appraisal policy for medical staff was reviewed in July 2023 and the Medical Appraisal Escalation Policy was reviewed in January 2023. With the new Humber Health Partnership group structure, policies and guidelines will be reviewed and standardised wherever possible to ensure consistency and alignment between the 2 Designated Bodies (Hull University Teaching Hospitals NHS Trust and Northern Lincolnshire and Goole NHS Foundation Trust. There is also the need to have a single electronic appraisal and revalidation system for both Organisations in the future and this is currently being reviewed as part of the appraisal system contract review.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

A peer review has not taken place. The new Operational Group structure between HUTH and NLaG will present opportunities for the group to review process, policies and procedures. At present, the Group will legally remain as two Designated Bodies (HUTH & NLaG) but with 1 Group Responsible Officer with effect from 1st July 2024.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Yes

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1]

Yes

7. Where, in the Question above this does not occur, there is full understanding of the reasons why and suitable action is taken.

Yes

8. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Yes – this is ratified via the Trust's Local Negotiating Committee and The Workforce Transformation Committee.

9. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

No – due to the increase in doctors for whom HUTH is the Designated Body, it is proving a challenge for the HUTH Revalidation Team to provide all doctors with access to an appraiser who can conduct their annual appraisal.

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

This will ultimately have an impact on some doctors ability to revalidate unless more appraisers are trained and can take up the medical appraiser role in 2024/25.

The Senior e-Medical Workforce Officer has undertaken a gap analysis in June 2024 to identify the shortfall of appraisers. This highlighted that the Trust (HUTH) is currently 12 appraisers short of the required number to appraise all doctors in the Designated Body, which equates to around 3.5 PA's, however to allow some flexibility in the system, the Trust should look to recruit a further 12-15 appraisers.

The Senior e-Medical Workforce Officer has provided the Group Responsible Officer (Dr Ananthakrishnan Ananthasayanam) with a list of new Consultants who have joined HUTH in the last 3 years and Dr Ananthasayanam will write to these Consultants to determine whether they would be interested in training to become new appraisers.

This topic continues to be discussed at the monthly Revalidation and Appraisal Committee chaired by the Responsible Officer and the committee continues to explore ways to remedy this situation.

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Yes – the Senior Appraiser Team and HUTH Revalidation Team ensures the training of the Appraiser team is up-to-date, deliver training to new Appraisers and perform Quality Assurance (QA) of appraisals. There is an annual Appraiser Network meeting which provides the opportunity for the Trust's Appraisers to share best practice and receive updates on local and national processes surrounding revalidation and appraisal. The last network meeting occurred in May 2024.

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Yes - All appraisal inputs and outputs of those Doctors due for revalidation are reviewed by the Senior Appraiser Team and HUTH Revalidation Team prior to the monthly Revalidation Panel chaired by the RO. The Senior Appraiser Team undertook a QA exercise on a 10% sample of appraisal output forms for 2023/24. The QA was completed using a locally designed QA template called HUTH Appraisal Summary & PDP Audit Tool (HASPAT). Results showed that 83% of outputs reviewed were scored as satisfactory to excellent, with

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

constructive feedback provided to those appraisers whose output forms were scored less than satisfactory. Constructive feedback provided to Appraisers by the Senior Appraiser Team is also used in the ongoing Appraiser training programme.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Total number of Doctors with a prescribed connection as at 31 March 2024	**774**
Total number of appraisals undertaken between 1 April 2023 and 31 March 2024	723
Total number of appraisals not undertaken between 1 April 2023 and 31 March 2024	51
Total number of agreed exceptions	42

The Trust's medical appraisal figures are discussed monthly at every Health Group performance meeting, as well as at the monthly Revalidation and Appraisal Committee chaired by the Responsible Officer. Those doctors with an appraisal date that is categorised as an '*unapproved missed appraisal'* are managed under the Trust's Medical Escalation Policy.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Yes – the Trust made 101 revalidation recommendations in 2023/24; 99 positive and 2 deferrals. The 2 deferrals were submitted due to the doctors requiring completion of their appraisal and multi-source feedback. In summary, 98% of recommendations submitted by the RO in 2023/24 were for a positive recommendation.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Yes

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Yes

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Yes

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Yes - Where there is concern about a Doctor's conduct or capability this is managed under the Trust's Maintaining High Professional Standards Policy. In all cases involving capability, and where appropriate in cases of possible misconduct, the investigation process would be conducted in consultation with NHS Resolution (formerly the National Clinical Assessment Service, NCAS). If misconduct is substantiated a range of disciplinary sanctions, ranging from reflective learning to dismissal are available. If concerns regarding capability are substantiated, an appropriate course of action developed in conjunction with NHS Resolution may be put in place. In the majority of capability cases the first option is to consider remediation and support. In addition to local Trust investigations Doctors may also be subject to investigation by the GMC. Where appropriate. this is as a result of the Trust reporting the result of a local investigation to the GMC, but more commonly the Doctor has been referred to the GMC by someone else (patient, relative, previous employer, etc.). The Trust cooperates fully with any GMC investigation into employees.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and

outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Yes

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Yes – the Responsible Officer Transfer Form continues to be used by the HUTH Revalidation Team to be completed by the RO from the prospective employee's previous organisation: this includes revalidation date, date of last appraisal and any concerns arising from appraisal, details of ongoing or previous GMC/NHS Resolution investigations (formerly NCAS), local conditions or undertakings, and any unresolved performance concerns. The prospective RO is informed accordingly.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Yes:

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.
[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Yes - The Trust's Employee Service Centre (HR department) has in place a system for checking identity, current and previous GMC conditions or undertakings, appropriate recent references, details of last (or current) Responsible Officer, qualification check, and police clearance.

Section 6 – Summary of comments, and overall conclusion

- The Trust has a Responsible Officer, who is appropriately trained and supported to perform the role
- The Trust has complied with its obligations as a Designated Body, and has appropriate procedures in place to make recommendations to the General Medical Council on revalidation
- The Trust has appropriate governance structures, policies, and procedures in place to ensure as far as possible that its medical workforce is fit to practise and complies with GMC Good Medical Practice
- There is a robust appraisal system in place, which is developmental and formative in nature.
- The Trust has a Medical Appraisal Escalation Policy to ensure that those Doctors whose appraisal is not undertaken within the required timescales are given the appropriate steps to follow. This policy was reviewed and updated in January 2023 and has been ratified by the Local Negotiating Committee (LNC)
- The Trust continues to achieve the 90% NHS England appraisal target
- The Trust was visited by NHS England in March 2024 as part of a Higher Level Responsible Officer Quality Review (HLROQR) – feedback was very positive with NHSE complementing the Trust, appraisal programme and HUTH Revalidation Team on the policies and procedures in place
- Maintaining a high level of appraisal rate is reliant on the continued implementation of an electronic platform, continuing essential

administrative support and the Trust having sufficient numbers of trained medical Appraisers to deliver a successful appraisal programme

- The Trust must look to recruit more medical appraisers to meet the increasing number of doctors for whom HUTH is the Designated Body for

Section 7 – Statement of Compliance:

The Board of Hull University Teaching Hospitals NHS Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: **Hull University Teaching Hospitals NHS Trust**

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)161

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	8 August 2024
Director Lead	Simon Parkes, NED / Chair of NLAG Audit, Risk and Governance Committee
Contact Officer / Author	Simon Parkes Sally Stevenson – Assistant Director of Finance – Compliance and Counter Fraud
Title of Report	**NLAG Audit, Risk and Governance Committee Annual Report to the Trust Board 2023/24**
Executive Summary	The attached report summarises the Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) Audit, Risk and Governance (ARG) Committee's key work during the past year, providing assurance as to how it has discharged its duties. Of note during 2023/24 is the move to group model with Hull University Teaching Hospitals NHS Trust (HUTH) and aligned governance and decision making through a committees-in-common approach. As a result, the Committee commenced meeting simultaneously with the HUTH ARG Committee from January 2024 having developed aligned Membership and Terms of Reference (ToR) documents and an aligned annual work plan. Further key points to note from 2023/24 are: • The Committee was quorate for all meetings during the year with excellent attendance by members and regular attendees. • The annual self-assessment exercise undertaken in January 2024 did not identify any gaps in the Committee's processes. The Healthcare Financial Management Association (HFMA) published the latest version of its NHS Audit Committee Handbook in March 2024. The new Handbook was reviewed against the ARG Committee's existing ToR and workplan and a limited number of minor adjustments are to be proposed to the Trust Board for approval. • The Committee has actively reviewed all key year end financial statements and associated reports (draft annual accounts, audited accounts, annual governance statement, head of internal audit opinion, external audit completion report and auditors annual report, etc.). • A positive Head of Internal Audit Opinion was received. • Internal Audit recommendations are monitored by the Committee with the receipt of an overdue recommendations report at each meeting of the Committee. A deterioration in overdue recommendations has been seen since 31 March 2024. The Committee will continue to closely monitor the position with implementing recommendations resulting from Internal Audit work.

	The Committee will continuously assess its effectiveness to operate as a committee-in-common with HUTH's ARG Committee over the coming year for the benefit of the group – NHS Humber Health Partnership. **The NLAG Trust Board is asked to note the 2023/24 Annual Report from the NLAG Audit, Risk and Governance Committee.**
Background Information and/or Supporting Document(s) (if applicable)	-
Prior Approval Process	July 2024 NLAG ARG Committee meeting.
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

Northern Lincolnshire and Goole NHS Foundation Trust

AUDIT, RISK AND GOVERNANCE COMMITTEE

ANNUAL REPORT

FOR THE YEAR ENDED 31 MARCH 2024

Simon Parkes – Non-Executive Director
Chair of Audit, Risk and Governance Committee

25 July 2024

1. Introduction and Purpose of the Report

The Audit, Risk and Governance Committee of Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) is established under Trust Board delegation with approved terms of reference that are aligned with the latest NHS Audit Committee Handbook (2024), as published by the Healthcare Financial Management Association (HFMA).

The Audit, Risk and Governance Committee independently reviews, monitors and reports to the Board on the effectiveness of control systems and financial reporting processes.

Following agreement by the Trust Boards of Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) and Hull University Teaching Hospitals NHS Trust (HUTH) to move to a group model and aligned governance and decision making through a committees-in-common approach, the NLAG Audit, Risk and Governance Committee commenced meeting simultaneously with the HUTH Audit Committee from January 2024, but remain separately constituted committees. The two committees are known as the Audit, Risk and Governance Committees-in-Common (ARG CiC).

This report sets out how the NLAG Committee satisfied its terms of reference during 2023/24 and provides the Board with assurance to underpin its responsibilities for the Annual Governance Statement (AGS). It is anticipated that this report will be submitted to the August 2024 Trust Board meeting.

2. Terms of Reference and Annual Work Plan

The Membership and Terms of Reference for the Committee are subject to regular review and revision as necessary. As a result of the move to a committees-in-common approach, aligned Membership and Terms of Reference documents were designed, as well as an aligned annual workplan, and these were duly approved by the Trust Boards in December 2023.

The HFMA also published its latest version of its NHS Audit Committee Handbook on 21 March 2024, replacing the previous one from 2018. The new Handbook has had a complete re-write and was duly reviewed against the ARG CiC's existing Membership and Terms of Reference to identify any particular issues the CiC may need to consider. A limited number of minor adjustments were considered at the April 2024 meeting of the ARG CiC and these are due to be presented to the Trust Board for approval.

As part of the Committee's regular review of its own governance arrangements, it once again undertook a self-assessment exercise in January 2024 using the 2018 HFMA NHS Audit Committee Handbook self-assessment checklist in place at that time. This exercise was undertaken separately by both the NLAG and HUTH Committee's, given that it was a reflective exercise looking back at the Committee's arrangements prior to implementing the committees-in-common approach. This exercise did not identify any gaps in the Committee's processes or terms of reference. The results of this latest exercise were submitted to the Trust Board for information in February 2024.

The latest HFMA Handbook also contains an updated self-assessment checklist and the eight new questions contained within it were also considered by the ARG CiC at its April 2024 meeting in terms of the current status of how those questions would be answered by the ARG CiC. No issues of concern were identified in relation to the eight new questions.

3. Membership and Attendance

The Committee consists of three non-executive directors (NEDs), of which two must be present at a meeting of the Committee for it to be quorate. The Committee has been chaired by Simon Parkes, NED, since October 2021. NED members throughout the year were Gill Ponder and Kate Truscott. There is cross NED membership with other Trust Board sub-committees-in-common.

The Committee continued to meet virtually via MS Teams throughout 2023/34, with this format continuing to work well allowing ad-hoc attendees to dial in only for their item at their designated time slot meaning more efficient use of their time. With the advent of CiC's there has been a move to a hybrid approach to ARG CiC meetings, with ARG CiC members and Trust officers in attendance in person in the meeting room whilst auditors and other ad-hoc attendees dial in to the meeting via MS Teams. This hybrid approach will be kept under review throughout the year to ensure effective operation of the meeting.

The Committee met on five occasions during 2023/24 - four full meetings plus an additional meeting in December 2023 for the audited accounts 2022/23 to be received prior to sign off by the Trust Board. The Committee discharged its responsibilities for scrutinising risks and controls that affect all aspects of the Trust's business.

A record of attendance by Committee members, regular and ad-hoc attendees is provided at **Appendix 1**. The record once again shows excellent attendance from both core members and regular attendees, with a good cross section of other officers attending on an ad-hoc basis to provide assurance to the Committee on various matters as and when necessary.

4. Principal Review Areas

4.1 Governance, Risk Management and Internal Control

During 2023/24 the Committee reviewed relevant disclosure statements, in particular the Annual Governance Statement (AGS), the Head of Internal Audit Opinion (HoIAO) and External Audit opinion for 2022/23. As a result of difficulties experienced in appointing an External Auditor the 2022/23 annual accounts and report process was not completed until December 2023, following agreement of revised submission dates with NHS England (NHSE) for 2022/23 and 2023/24. Further details on this can be found in section 4.4 of this report.

In terms of the 2023/24 year end documents, the Committee reviewed the draft accounts, AGS and HoIAO at its April 2024 meeting. These will all be finalised however by August 2024, in line with the revised submission deadline agreed with NHSE.

The Committee received reports during the year (July and November 2023) on the Trust's Board Assurance Framework and Strategic Risk Register (BAF/SRR). The Committee also reviewed and commented on certain risks and their associated scores contained within it. At its July 2023 meeting, it also received an update on the Annual Review of the Trust's Risk Management Strategy.

4.2 Internal Audit

The Trust's internal audit service is provided by Audit Yorkshire, who commenced in June 2018 with a contract for a period of three years, with the option to extend for a fourth and final year which was subsequently taken up following approval by the Committee. A further competitive procurement exercise commenced in January 2022 to award a new contract

commencing 1 June 2022. Audit Yorkshire were successful in being awarded a new three year contract with the Trust, commencing with the 2022/23 financial year, with the option to extend for a fourth and final year. An agreed Internal Audit Charter is in place with Audit Yorkshire.

The Committee received the Annual Internal Audit Report for 2022/23 from its internal auditors at its July 2023 meeting.

An internal audit plan was considered and agreed for 2023/24 at the April 2023 meeting of the Committee. As in previous years, the Committee sought to work effectively with Internal Audit throughout the year to review, assess and develop internal control processes as necessary. The Committee reviewed progress against the agreed internal audit work plan for 2023/24 via routine written progress reports from its internal auditor at each meeting, at which an internal audit representative was always present. Written progress reports outline the status of the planned audit work for the year and the outcome of individual reviews performed, along with associated recommendations where appropriate.

During 2023/24 Internal Audit completed 23 reviews. Assurance ratings, as to the adequacy and effectiveness of control arrangements in place were as follows:

- 1 review with High Assurance rating;
- 17 reviews with Significant Assurance rating;
- 5 reviews with Limited Assurance rating;
- 0 with Low Assurance rating.

The 2023/24 Head of Internal Audit Opinion was also received by the Committee which was as follows: ***Significant assurance can be given that there is a good system of governance, risk management and internal control designed to meet the organisation's objectives and that controls are generally being applied consistently.*** The 2023/24 HoIAO is included within the AGS, which forms part of the publicly available Trust Annual Report.

The Trust also formulated its annual internal audit plan for 2024/25, devising a Group internal audit plan as far as possible. A draft plan was considered by the Executive team and then refined into a programme of audits for the forthcoming year, in line with the allotted 200 day annual internal audit plan. The proposed Group internal audit plan for 2024/25 was presented to the April 2024 meeting of the Committees-in-Common for consideration and duly approved. The ARG CiC was pleased to see the two Trusts Internal Auditors had collaborated well to produce a plan of audit work for the coming year, with a number of audits to be undertaken jointly at both Trusts, working to one agreed scope and producing a single audit report where possible.

Audit Yorkshire operates an electronic follow-up process for all recommendations made, which involves the relevant managers receiving automated prompts to provide periodic updates and evidence, via the electronic system, on the implementation status of recommendations, including those considered to be closed. A routine report is prepared by Audit Yorkshire to show the status of recommendations made, and this is presented to each meeting of the Committee for assurance or the consideration of further action as appropriate. An overall generally positive position has been maintained in respect of overdue recommendations through 2023/24, with six overdue as at 27 March 2024. However 29 recommendations became overdue at 31.3.24 and Audit Yorkshire therefore reported a deteriorating position at the April 2024 meeting with 33 recommendations overdue for implementation. At the time of producing this report the number overdue stands at 29. The Committee will continue to

routinely monitor the implementation of audit recommendations over the coming year and address any concerns relating to lack of progress if the need arises.

4.3 Counter Fraud

The Audit, Risk and Governance Committee continued to receive regular written progress reports from the Trust's Local Counter Fraud Specialist (LCFS) throughout the year. Additionally, the Annual Counter Fraud Report for 2022/23 and the Annual Counter Fraud Operational Plan for 2023/24 were also submitted to the Committee during the reporting year. The Trusts Counter Fraud Functional Standard Return (CFFSR) was also prepared and duly submitted to the NHS Counter Fraud Authority by the deadline of 31 May 2023. This was assessed as a Green rating overall.

The Committee remained pleased by the level of counter fraud activities performed by the LCFS during 2023/24, notably reaching 94% compliance with mandatory fraud awareness eLearning for all staff every three years, having only been introduced in mid-January 2023.

The Trust continues to host and manage an in-house counter fraud collaborative, known as Counter Fraud Plus (CFP) between itself, Hull University Teaching Hospitals NHS Trust (HUTH), Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, United Lincolnshire Hospitals NHS Trust, Lincolnshire Partnership NHS Foundation Trust (LPFT) and Lincolnshire Community Health Services NHS Trust (LCHS). This collaborative arrangement commenced in July 2013 (with LPFT and LCHS joining in September 2020 and HUTH in April 2023) under a formal SLA arrangement. It is designed to provide a more resilient counter fraud service between the organisations involved. The Committee has received reports that the collaborative continues to work effectively and successfully across all six local organisations.

4.4 External Audit

The Trust's External Auditor is Sumer AuditCo NI Ltd (formerly called ASM until 1 July 2024 when it was taken over and the contract novated), appointed in June 2023 following a procurement process supported by NHS England (NHSE) due to difficulties in the NHS audit market. Representatives of the Audit, Risk and Governance Committee act as advisors to the Council of Governors in relation to the appointment of an External Auditor. ASM were awarded a contract for three years plus an option to extend for a further two years (one plus one).

As a result of the difficulties and resulting delay in appointing an External Auditor NHSE agreed to extended accounts submission deadlines, namely 31 December 2023 for the 2022/23 audit and 23 August 2024 for the 2023/24 audit. Future years will revert to scheduled NHSE submission deadlines. Timings for the 2023/24 audit are as follows:

2023-24

- Planning visits – December 2023 / January 2024
- Interim – February / March 2024
- Fieldwork – commencing mid-June 2024 for 4 weeks (with one week follow up)
- Completion – w/c 6 August 2024
- Submission to NHSE – by 23 August 2024

Oral or written progress reports are received from the Trust's External Auditor at Committee meetings, including the audit opinion on the Trust's annual financial statements. However, there was no External Auditor presence at the April 2023 meeting, with ASM only commencing in June 2023, as shown in Appendix 1.

During the year a private meeting with both the external and internal auditors took place before the November 2023 meeting of the Committee, and no matters of concern were raised. However, in line with its Terms of Reference, there is an open offer to all parties (the Trust, external auditors and internal auditors) to request a private meeting at any time.

The Committee normally formally consider the performance of the Trust's External Auditor at its July meeting each year following the conclusion of their year-end accounts work, however this will be done for the first time with ASM at the October 2024 meeting (following conclusion of their audit work in August 2024). However, the Committee has been pleased with the service provided by ASM since they commenced providing External Audit services to the Trust in June 2023.

In line with Regulator guidance, the Trust has a '*Policy for Engagement of External Auditors for Non-Audit Work*' to avoid any potential conflicts of interest, either real or perceived, in terms of the objectivity of their opinion on the financial statements of the Trust. The policy, which can be found on the documents section of the Trust intranet, is subject to annual review and minor revisions (e.g. job titles) were duly considered and approved by the Committee at its January 2024 meeting. The value of non-audit services is routinely disclosed in the Trust's accounts, however there was no such work performed by ASM during 2023/234.

5. Financial Reporting

At its April and December 2023 meetings the Committee reviewed the draft and audited annual financial statements for 2022/23 before submission to the External Auditor (draft accounts) and NHS England (draft and audited accounts), and we understand these were in agreement with our accounting records and the current Regulatory requirements.

At the April 2024 Committee meeting the issue of 'Going Concern' status was discussed. As a result, the Committee endorsed the view that the Trust is a going concern for the purposes of the annual accounting exercise. This was agreed by the External Auditor. The Committee reviewed and agreed the detailed accounting principles for the 2023/24 accounts at its April 2024 meeting. The Committee also reviewed the draft annual accounts for 2023/24.

Given the difficulties appointing an External Auditor, as referred to earlier, there is an extended timescale for the audit of the 2023/24 draft accounts and associated disclosure documents and their submission to NHSE, etc. The Committee have therefore yet to receive the audited financial statements for 2023/24 (which under normal circumstances would have been received at a meeting of the Committee in June 2024). The Committee will oversee the completion of the 2023/24 process by August 2024, in line with the revised timetable agreed with NHSE.

The audited financial statements for 2023/24 are scheduled to be reviewed at a meeting of the Committee on 6 August 2024, following which it is expected that they will be endorsed by the Committee for approval by the Trust Board on 8 August 2024.

6. Management Reports

The Committee has requested and reviewed various management assurance reports from a range of Directors and managers within the organisation in relation to relevant areas of enquiry during the financial year 2023/24 in line with the Committee's annual work plan and on an ad-hoc basis. We thank all those who assisted the Committee in these matters.

7. Other Matters Worthy of Note

The Committee followed its agreed annual work plan throughout the year and received regular reports including Waiving of Standing Orders; Losses and Compensations; Hospitality and Sponsorship declarations; Salary Overpayments; and Document Control. Additional information is called for as appropriate. The Committee once again received the Local Security Management Specialist (LSMS) work plan and annual report for information and assurance.

Throughout the year the Committee also received the highlight reports and action logs from the Trust's main assurance Trust Board sub-committees in order to assess the effectiveness of the Trust's governance arrangements.

Minutes of the Committee's meetings and a Chair's Highlight Report of matters to be escalated are submitted to the Trust Board for information, assurance or decision as necessary.

The Committee members would like to place on record their thanks to the Trust's External Auditors (ASM), Internal Auditors (Audit Yorkshire), and our in-house counter-fraud service. All have provided a professional and effective service during 2023/24.

8. Conclusion and Plans for 2024/25

The Audit, Risk and Governance Committees-in-Common aligned annual work plan for 2024/25 is attached at **Appendix 2**.

The Committees will remain active in reviewing the risks, internal controls, reports of auditors and audit recommendations and will continue to press for action and improvements where required throughout the coming year.

The Audit, Risk and Governance Committees-in-Common will continuously assess its effectiveness to operate as committees-in-common for the benefit of the Group - NHS Humber Health Partnership.

The Council of Governors will also receive a copy of this annual report and work plan.

Appendix 1 - Schedule of Attendance at Audit, Risk and Governance Committee meetings during 2023/24

Member / Attendee	Apr-23	Jul-23	Nov-23	Dec-23	Jan-24
Members:					
Simon Parkes – NED / Chair	**Y**	**Y**	**Y**	**Y**	**Y**
Gill Ponder – NED	**Y**	**Y**	**Y**	**Y**	**Y**
Kate Truscott – NED	**Y**	**Y**	**Y**	**Y**	**Y**
Regular Attendees:					
Lee Bond – Group Chief Financial Officer	**Y**	**Y**	**Y**	**Y**	**Y**
Helen Harris – Director of Corporate Governance	**Y**	**Y**	-	-	-
Wendy Booth – Interim Governance Advisor	-	-	**Y**	**Y**	**Y**
Sally Stevenson - Asst. DoF – Compliance & Counter Fraud	**Y**	**Y**	**Y**	**Y**	**Y**
Nicki Foley – Local Counter Fraud Specialist	**Y**	**Y**	**Y**	**N**[2]	**Y**
Data Protection Officer and Lead for IT (SM)	**Y**	**Y**	**Y**	**N**[2]	**Y**
Head of Procurement (IP)	**Y**	**Y**	**Y**	**N**[2]	**N**[3]
Internal Audit (Audit Yorkshire)	**Y**	**Y**	**Y**	**Y**	**Y**
External Audit (ASM)	-[1]	**Y**	**Y**	**Y**	**Y**
Governor Observer (Various)	**Y**	**Y**	**Y**	**Y**	**Y**
Group Chief Executive (JL)	-	-	-	**Y**	**N**
Ad-hoc Attendees:					
Asst. DoF – Planning & Control (NP)	**Y**	-	-	**Y**	-
Assistant Director of Corporate Governance (AH)	**Y**	-	-	-	-
Head of Safety & Statutory Compliance (RG)	**Y**	**Y**	-	-	-
Interim Chief Executive (SS)	-	**Y**	-	-	-
Associate Director of Quality Governance (RD)	-	**Y**	-	-	-
Chief Technology Officer (TD)	-	**Y**	-	-	**Y**
Associate Director of IM&T (SM)	-	**Y**	-	-	**Y**

Member / Attendee	Apr-23	Jul-23	Nov-23	Dec-23	Jan-24
Ad-hoc Attendees continued…					
Associate Director of Central Operations (MO)	-	-	**Y**	-	-
EPRR Manager (AL)	-	-	**Y**	-	-
Associate Director of Communications & Engagement (AB)	-	-	-	**Y**	-
Deputy Chief Operating Officer (AA)	-	-	-	-	**Y**

Notes:

[1] No External Auditor service in place
[2] Not required to attend, Final Accounts meeting only
[3] No longer required at each meeting

APPENDIX 2

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Audit, Risk & Governance Committees-in-Common Aligned Work Plan 2024 / 25

				Quarter 4 (23 / 24)			Quarter 1 (24/25)			Quarter 2 (24/25)			Quarter 3 (24/25)			Quarter 4 (24/25)			
Agenda Item	**Method of Reporting**	**Report Lead**	**Frequency**	**Jan** **25.1.24**	**Feb**	**Mar**	**Apr** **25.4.24**	**May**	**Jun** **19.6.24** **HUTH Public Disclosure Documents**	**Jul** **25.7.24**	**Aug** **15.8.24** **NLAG Public Disclosure Documents 23/24 only**	**Sep**	**Oct** **31.10.24**	**Nov**	**Dec**	**Jan** **23.1.25**	**Feb**	**Mar**	**Action**
Core Business Items																			
Minutes of the Previous Meetings	Written	Committee Chair	Quarterly	**X**			**X**			**X**			**X**			**X**			Approval
Matters Arising & Action Tracker (management & monitoring of committee actions)	Written	Committee Chair	Quarterly	**X**			**X**			**X**			**X**			**X**			Discussion & Assurance
Review / Self Assessment of Committee Effectiveness	Written	Committee Chair	Annually	**X**												**X**			Discussion & Assurance
Review of Committee Terms of Reference & Work Plans	Written	Committee Chair	Annually	**X**												**X**			Approval
Annual Report to the Trust Board (& Council of Governors for NLAG)	Written	Committee Chair	Annually						**X** **HUTH**		**X** **NLAG**								Approval
Annual Meeting Cycle	Written	Committee Chair	Annually										**X**						Noting
Matters Referred to the Committee																			
Matters referred by the Trust Boards or other Board Committees	Written	Committee Chair	As required	**To be added to the agenda as required**															Discussion
Matters referred to other Board Committees	Written	Committee Chair	As required	**To be added to the agenda / agreed at the relevant meeting as required (and recorded in the minutes & action log)**															Discussion
Committee Specific Business Items																			
Governance, Risk Management and Internal Control (including financial reporting):																			
Board Assurance Framework (BAF) - annual review of adequacy and effectiveness of system for devising and monitoring the BAF.	Written	Group Director of Assurance	Annually							**X**									Assurance
Risk Register - annual review of adequacy and effectiveness of system for the management and monitoring risk.	Written	Group Chief Medical Officer	Annually							**X**									Assurance
Annual Review of Risk Management Strategy / Development Plan Progress Report.	Written	Group Chief Medical Officer	Annually							**X**									Assurance
Review of Board Committees Conduct Risk Oversight including Minutes, Highlight Reports & Action Logs from Board Committees (excluding Remuneration)	Written	Committee Chairs	Quarterly	**X**			**X**			**X**			**X**			**X**			Assurance
Annual Summary of Remuneration Committees Business	Written	Trust Chair	Annually				**X**												Assurance
Public Disclosure Statements:																			
Going Concern Report and Review of Changes to Accounting Policies	Written	Group Chief Financial Officer	Annually				**X**												Discussion & Approval
Draft Annual Accounts & VFM Conclusion	Written	Group Chief Financial Officer	Annually				**X**												Discussion & Approval

Agenda Item	Method of Reporting	Report Lead	Frequency	Quarter 4 (23 / 24)			Quarter 1 (24/25)			Quarter 2 (24/25)			Quarter 3 (24/25)			Quarter 4 (24/25)			
				Jan 25.1.24	Feb	Mar	Apr 25.4.24	May	Jun 19.6.24 HUTH Public Disclosure Documents	Jul 25.7.24	Aug 15.8.24 NLAG Public Disclosure Documents 23/24 only	Sep	Oct 31.10.24	Nov	Dec	Jan 23.1.25	Feb	Mar	Action
Annual Governance Statement	Written	Group Director of Assurance	Annually				X Draft		X HUTH Final		X NLAG Final								Assurance
Audited Annual Accounts (under TB delegated authority if necessary)	Written	Group Chief Financial Officer	Annually						X HUTH		X NLAG								Discussion & Approval
Trust Annual Report (under TB delegated authority if necessary)	Written	Group Director of People	Annually						X HUTH		X NLAG								Assurance
Management Reports for Assurance:																			
Review of Waiving of Standing Orders	Written	Group Chief Financial Officer	Bi-annually				X						X						Assurance
Review of Losses & Compensation (inc. Special Payments & Write-Offs)	Written	Group Chief Financial Officer	Bi-annually				X						X						Assurance
Review of Standards of Business Conduct Declarations	Written	Group Director of Assurance	Bi-annually				X						X						Assurance
Review of Salary Overpayments and Underpayments	Written	Group Chief Financial Officer	Annually				X												Assurance
Review of Legal Fees and External Consultancy Fees	Written	Group Director of Assurance	Annually							X									Assurance
Review of Procurement KPI Data (including invoices without PO's and contracts update)	Written	Group Chief Financial Officer	Annually										X						Assurance
Annual Claims Report	Written	Group Chief Medical Officer	Annually							X									Assurance
Document Control Report	Written	Group Director of Assurance	Bi-annually				X						X						Assurance
Review of relevant external reports, recommendations & assurances, as appropriate e.g. CQC, NHS Resolution, Royal Colleges, accreditation bodies - Summary of who has been to the Trust and the outcome.	Written	Group Director of Assurance	As required	**To be added to the agenda as required**															Discussion & Assurance
Internal Audit:																			
Private discussion with the auditors (Internal & External)	Verbal	Committee Chair / Internal Auditor	As required						X HUTH		X NLAG								Discussion
Annual Internal Audit Plan	Written	Internal Auditor	Annually				X												Assurance
Internal Audit Routine Progress Report	Written	Internal Auditor	Quarterly				X			X			X			X			Assurance
Status Report on Implementation of Internal Audit Recommendations	Written	Internal Auditor	Quarterly				X			X			X			X			Assurance
Head of Internal Audit Opinion Statement	Written	Internal Auditor	Annually				X Draft		X HUTH Final		X NLAG Final								Assurance
Internal Audit Annual Report (including client feedback survey results and review of effectiveness KPIs)	Written	Internal Auditor	Annually						X HUTH	X NLAG									Assurance
Changes to Internal Audit Service Provider	Written	Group Chief Financial Officer	As required	**To be added to the agenda as required**															Approval
External Audit:																			
Private discussion with the auditors (Internal & External)	Verbal	Committee Chair / External Auditors	As required						X HUTH		X NLAG								Discussion
Audit Strategy Memorandum (Audit Plan / Timetable / Fees)	Written	External Auditor	Annually				X												Approval

				Quarter 4 (23 / 24)			Quarter 1 (24/25)			Quarter 2 (24/25)			Quarter 3 (24/25)			Quarter 4 (24/25)			
Agenda Item	**Method of Reporting**	**Report Lead**	**Frequency**	**Jan** **25.1.24**	**Feb**	**Mar**	**Apr** **25.4.24**	**May**	**Jun** **19.6.24** **HUTH Public Disclosure Documents**	**Jul** **25.7.24**	**Aug** **15.8.24** **NLAG Public Disclosure Documents 23/24 only**	**Sep**	**Oct** **31.10.24**	**Nov**	**Dec**	**Jan** **23.1.25**	**Feb**	**Mar**	**Action**
External Audit Routine Progress Report	Written or verbal as appropriate	External Auditor	Quarterly	**X**			**X**			**X**			**X**			**X**			Assurance
Audit Completion Report & Letter of Representation	Written	External Auditor	Annually						**X** **HUTH**		**X** **NLAG**								Assurance
Auditor's Annual Report	Written	External Auditor	Annually						**X** **HUTH**		**X** **NLAG**								Assurance
Annual Review of External Auditor Performance	Written	Group Chief Financial Officer	Annually										**X**						Assurance
Changes to Service Provider (+ support to the Council of Governors - NLaG)	Written	Group Chief Financial Officer	As required	**To be added to the agenda as required**															Discussion
Counter Fraud																			
Annual Counter Fraud Operational Plan	Written	LCFS	Annually				**X**												Assurance
Annual Counter Fraud Report	Written	LCFS	Annually							**X**									Assurance
LCFS Progress Reports	Written	LCFS	Quarterly	**X**			**X**			**X**			**X**			**X**			Assurance
Annual Review of Fraud & Corruption Policy	Written	LCFS	Annually				**X**												Assurance
Results of Staff Fraud Awareness Survey	Written	LCFS	Two Yearly							**X**									Assurance
Emergency Preparedness, Resilience & Response (EPRR)																			
Annual EPRR and Business Continuity Report including Medical Gas Testing Oversight	Written	Group Chief Delivery Officer	Annually							**X**									Assurance
Information Governance (IG) & Cyber Security																			
Annual review of the Trusts' IG & cyber security arrangements *(private agenda item)*	Written	Group Digital Information Officer	Annually							**X**									Assurance
Annual IG Toolkit Return	Written	DPO / Information Governance Lead	Annually							**X**									Assurance
IG Steering Group Highlight Report	Written	DPO / Information Governance Lead	Quarterly	**X**			**X**			**X**			**X**			**X**			Assurance
Systems for Raising Concerns:																			
Annual review of the Trusts' arrangements for Raising Concerns / Freedom to Speak Up (FTSU)	Written	FTSU Guardian	Annually	**X**												**X**			Assurance
Governance & Regulatory Compliance:																			
Compliance with the NHS Provider Licence	Written	Group Director of Assurance	Annually						**X**		**X**								Assurance
Compliance with the NHS Code of Governance	Written	Group Director of Assurance	Annually						**X**		**X**								Assurance
Compliance with the Fit & Proper Persons Test	Written	Group Director of Assurance	Three Yearly				**X**												Assurance
Policy Review																			
Finance Related Policies (SFIs / Standing Orders / Scheme of Delegation / Recovery of Salary Overpayments Policy)	Written	Group Chief Financial Officer	Three Yearly / As Required	**To be added to the agenda as required**															Approval and / or Endorse for Board

				Quarter 4 (23 / 24)			Quarter 1 (24/25)			Quarter 2 (24/25)			Quarter 3 (24/25)			Quarter 4 (24/25)			
Agenda Item	**Method of Reporting**	**Report Lead**	**Frequency**	**Jan** **25.1.24**	**Feb**	**Mar**	**Apr** **25.4.24**	**May**	**Jun** **19.6.24** **HUTH Public Disclosure Documents**	**Jul** **25.7.24**	**Aug** **15.8.24** **NLAG Public Disclosure Documents 23/24 only**	**Sep**	**Oct** **31.10.24**	**Nov**	**Dec**	**Jan** **23.1.25**	**Feb**	**Mar**	**Action**
Annual Review of Policy for Engagement of External Auditors for External Audit Work	Written	Group Chief Financial Officer	Annually	**X**												**X**			Approval
Standards of Business Conduct Policy	Written	Group Director of Assurance	Three Yearly				**X**												
Notes:																			
1. This work plan reflects the core business of the Audit, Risk & Governance Committees-in-Common. Topical / emerging issues will be added to the committees' agenda as required.																			

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)162

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	8 August 2024
Director Lead	Jane Hawkard, NED / Chair of HUTH Audit, Risk and Governance Committee
Contact Officer / Author	Jane Hawkard Sally Stevenson – Assistant Director of Finance – Compliance and Counter Fraud
Title of Report	**HUTH Audit, Risk and Governance Committee Annual Report to the Trust Board 2023/24**
Executive Summary	The attached report summarises the Hull University Teaching Hospitals NHS Trust (HUTH) Audit, Risk and Governance (ARG) Committee's key work during the past year, providing assurance as to how it has discharged its duties. Of note during 2023/24 is the move to group model with Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) and aligned governance and decision making through a committees-in-common approach. As a result, the Committee commenced meeting simultaneously with the NLAG ARG Committee from January 2024 having developed aligned Membership and Terms of Reference (ToR) documents and an aligned annual work plan. Further key points to note from 2023/24 are: • Jane Hawkard, NED, commenced with the Trust as Audit Committee Chair from October 2023. • The Committee was quorate for all meetings during the year with excellent attendance by members and regular attendees. • The annual self-assessment exercise undertaken in January 2024 did not identify any gaps in the Committee's processes. The Healthcare Financial Management Association (HFMA) published the latest version of its NHS Audit Committee Handbook in March 2024. The new Handbook was reviewed against the ARG Committee's existing ToR and workplan and a limited number of minor adjustments are to be proposed to the Trust Board for approval. • The Committee has actively reviewed all key year end financial statements and associated reports (draft annual accounts, audited accounts, annual governance statement, head of internal audit opinion, external audit completion report and auditors annual report, etc.). • A positive Head of Internal Audit Opinion was received. • Internal Audit recommendations are monitored by the Committee with the receipt of an overdue recommendations report at each meeting of the Committee. A positive reduction in overdue recommendations has been seen over the course of the year. The Committee will continue to closely monitor the position with implementing recommendations resulting from Internal Audit work.

	The Committee will continuously assess its effectiveness to operate as a committee-in-common with NLAG's ARG Committee over the coming year for the benefit of the group – NHS Humber Health Partnership. **The HUTH Trust Board is asked to note the 2023/24 Annual Report from the HUTH Audit, Risk and Governance Committee.**
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	June 2024 HUTH ARG Committee meeting.
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

Hull University Teaching Hospitals NHS Trust

AUDIT, RISK AND GOVERNANCE COMMITTEE

ANNUAL REPORT

FOR THE YEAR ENDED 31 MARCH 2024

Jane Hawkard – Non-Executive Director
Chair of Audit, Risk and Governance Committee

21 June 2024

1. Introduction and Purpose of the Report

The Audit, Risk and Governance Committee (formerly called the Audit Committee until January 2024) of Hull University Teaching Hospitals NHS Trust is established under Trust Board delegation with approved terms of reference that are aligned with the latest NHS Audit Committee Handbook (2024), as published by the Healthcare Financial Management Association (HFMA).

The Audit, Risk and Governance Committee independently reviews, monitors and reports to the Board on the effectiveness of control systems and financial reporting processes.

Following agreement by the Trust Boards of Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) to move to a group model and aligned governance and decision making through a committees-in-common approach, the HUTH Audit Committee commenced meeting simultaneously with the NLAG Audit, Risk and Governance Committee from January 2024, but remain separately constituted committees. The two Committees are known as the Audit, Risk and Governance Committees-in-Common (ARG CiC).

This report sets out how the HUTH Committee satisfied its terms of reference during 2023/24 and provides the Board with assurance to underpin its responsibilities for the Annual Governance Statement (AGS). It is anticipated that this report will be submitted to the August 2024 Trust Board meeting.

2. Terms of Reference and Annual Work Plan

The Membership and Terms of Reference for the Committee are subject to regular review and revision as necessary. As a result of the move to a committees-in-common approach, aligned Membership and Terms of Reference documents were designed, as well as an aligned annual workplan, and these were duly approved by the Trust Boards in December 2023.

The HFMA also published its latest version of its NHS Audit Committee Handbook on 21 March 2024, replacing the previous one from 2018. The new Handbook has had a complete re-write and was duly reviewed against the ARG CiC's existing Membership and Terms of Reference to identify any particular issues the CiC may need to consider. A limited number of minor adjustments were considered at the April 2024 meeting of the ARG CiC and these are due to be presented to the Trust Board for approval.

As part of the Committee's regular review of its own governance arrangements, it once again undertook a self-assessment exercise in January 2024 using the 2018 HFMA NHS Audit Committee Handbook self-assessment checklist in place at that time. This exercise was undertaken separately by both the HUTH and NLAG Committee's, given that it was a reflective exercise looking back at the Committee's arrangements prior to implementing the committees-in-common approach. This exercise did not identify any gaps in the Committee's processes or terms of reference. The results of this latest exercise were submitted to the Trust Board for information in February 2024.

The latest HFMA Handbook also contains an updated self-assessment checklist and the eight new questions contained within it were also considered by the ARG CiC at its April 2024 meeting in terms of the current status of how those questions would be answered by the ARG CiC. No issues of concern were identified in relation to the eight new questions.

3. Membership and Attendance

The Committee consists of three non-executive directors (NEDs), of which two must be present at a meeting of the Committee for it to be quorate. The Committee has been chaired by Jane Hawkard, NED, since October 2023 following the departure of the former Chair, Tracey Zepherin. NED members throughout the year were Mike Robson (Vice Chair of the Committee, chairing June and July 2023 meetings) and Tony Curry. There is cross NED membership with other Trust Board sub-committees-in-common.

The Committee continued to meet virtually via MS Teams throughout 2023/34, with this format continuing to work well allowing ad-hoc attendees to dial in only for their item at their designated time slot meaning more efficient use of their time. With the advent of CiC's there has been a move to a hybrid approach to ARG CiC meetings, with ARG CiC members and Trust officers in attendance in person in the meeting room whilst auditors and other ad-hoc attendees dial in to the meeting via MS Teams. This hybrid approach will be kept under review throughout the year to ensure effective operation of the meeting.

The Committee met on five occasions during 2023/24 - four full meetings plus an additional meeting in June 2023 for the audited accounts 2022/23 to be received prior to sign off by the Trust Board. The Committee discharged its responsibilities for scrutinising risks and controls that affect all aspects of the Trust's business.

A record of attendance by Committee members, regular and ad-hoc attendees is provided at **Appendix 1**. The record shows excellent attendance from both core members and regular attendees, with a good cross section of other officers attending on an ad-hoc basis to provide assurance to the Committee on various matters as and when necessary.

4. Principal Review Areas

4.1 Governance, Risk Management and Internal Control

During 2023/24 the Committee reviewed relevant disclosure statements, in particular the Annual Governance Statement (AGS), the Head of Internal Audit Opinion (HoIAO) and External Audit opinion for 2022/23.

In terms of the 2023/24 year end documents, the Committee reviewed the draft accounts, AGS and HoIAO at its April 2024 meeting, and the audited accounts and final versions of the AGS and HoIAO at its June 2024 meeting.

The Committee received a report on the Trust's Board Assurance Framework (BAF) and the process by which it is used by the Board and its committees, at its July and October 2023 meetings. It received the Q2 BAF for review at its October 2023 meeting also. An update on the Trust's Risk Management Strategy was received at the July 2023 meeting.

4.2 Internal Audit

The Trust's internal audit service is provided by RSM, who commenced in April 2019. RSM were successful in being awarded a new two year contract with the Trust from 1 April 2023, commencing with the 2023/24 financial year, with the option to extend for a third and final year. An agreed Internal Audit Charter is in place with RSM.

The Committee received the Annual Internal Audit Report for 2022/23 from its internal auditors at its June 2023 meeting.

An internal audit plan was considered and agreed for 2023/24 at the April 2023 meeting of the Committee. As in previous years, the Committee sought to work effectively with Internal Audit throughout the year to review, assess and develop internal control processes as necessary. The Committee reviewed progress against the agreed internal audit work plan for 2023/24 via routine written progress reports from its internal auditor at each meeting, at which an internal audit representative was always present. Written progress reports outline the status of the planned audit work for the year and the outcome of individual reviews performed, along with associated recommendations where appropriate.

During 2023/24 Internal Audit performed ten reviews, with nine reported at the time of producing this report. Assurance ratings, as to the adequacy and effectiveness of control arrangements in place, for the nine reported reviews were as follows:

- 2 reviews with Substantial Assurance rating;
- 5 reviews with Reasonable Assurance rating;
- 1 review with Partial Assurance rating;
- 1 review with Good Progress;
- 0 with Minimal Assurance rating.

The 2023/24 Head of Internal Audit Opinion was also received by the Committee which was as follows: ***The organisation has an adequate and effective framework for risk management, governance and internal control.*** **However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.** The 2023/24 HoIAO is included within the AGS, which forms part of the publicly available Trust Annual Report.

The Trust also formulated its annual internal audit plan for 2024/25, devising a Group internal audit plan as far as possible. A draft plan was considered by the Executive team and then refined into a programme of audits for the forthcoming year, in line with the allotted 200 day annual internal audit plan for the Trust. The proposed Group internal audit plan for 2024/25 was presented to the April 2024 meeting of the ARG CiC for consideration and duly approved. The ARG CiC was pleased to see the two Trusts Internal Auditors had collaborated well to produce a plan of audit work for the coming year, with a number of audits to be undertaken jointly at both Trusts, working to one agreed scope and producing a single audit report where possible.

RSM provide an electronic follow-up system for all recommendations made for utilsation by the Trust, which involves the relevant managers receiving automated prompts to provide periodic updates and evidence, via the electronic system, on the implementation status of recommendations, including those considered to be closed. A routine report is prepared by RSM, to show the status of recommendations made, and since July 2023 is now presented to each meeting of the Committee for assurance or the consideration of further action as appropriate. The Committee has seen a positive reduction in the number of overdue recommendations over the last year. RSM reported 16 overdue recommendations at the April 2024 meeting but this has continued to fall and at the time of producing this report the number overdue stands at five. The Committee will continue to routinely monitor the implementation of audit recommendations over the coming year and address any concerns relating to lack of progress if the need arises.

4.3 Counter Fraud

The Trust changed its counter fraud service from RSM in April 2023 and joined the in-house counter fraud collaborative, known as Counter Fraud Plus (CFP) which has been hosted by NLAG since July 2013 and includes Doncaster and Bassetlaw Teaching Hospitals NHS

Foundation Trust, United Lincolnshire Hospitals NHS Trust, Lincolnshire Partnership NHS Foundation Trust (LPFT) and Lincolnshire Community Health Services NHS Trust (LCHS). It is designed to provide a more resilient counter fraud service between the organisations involved.

The Committee received regular written progress reports from the Trust's Local Counter Fraud Specialist (LCFS) throughout the year. Additionally, the Annual Counter Fraud Report for 2022/23 (produced by RSM) and the Annual Counter Fraud Operational Plan for 2023/24 were also submitted to the Committee during the reporting year. The Trusts Counter Fraud Functional Standard Return (CFFSR) was also compiled by the former provider, RSM, and this was duly submitted to the NHS Counter Fraud Authority by the deadline of 31 May 2023. This was assessed as a Green rating overall.

The LCFS continued working to raise awareness of NHS fraud and develop a strong anti-fraud culture, whilst at the same time investigating allegations of fraud to a criminal standard. The Committee has actively supported the work of the LCFS, and support a move to mandatory fraud awareness training at the Trust, to align itself with NLaG in this regard and ensure a consistent group approach.

4.4 External Audit

The Trust's External Auditor is Mazars, appointed in April 2020. The Committee acts as the Trust's 'Auditor Panel' in relation to the selection and appointment of an External Auditor and make a recommendation to the Board for approval. Following a further competition exercise in December 2023, Mazars were successful in being awarded a further contract for two years plus an option to extend for a further two years (one plus one). This was approved by the Trust Board at its meeting in April 2024.

Oral or written progress reports are received from the Trust's External Auditor at Committee meetings, including the audit opinion on the Trust's annual financial statements. Mazars attended all meetings during the year with the exception of July 2023.

A private meeting with both the external and internal auditors took place before the October 2023 meeting of the Committee, and no matters of concern were raised. However, in line with its Terms of Reference, there is an open offer to all parties (the Trust, external auditors and internal auditors) to request a private meeting at any time. The Committee also formally considered the performance of the Trust's External Auditor at its October 2023 meeting. No issues of concern were identified as part of the evaluation.

In line with Regulator guidance, the Trust has a '*Policy for Engagement of External Auditors for Non-Audit Work*' to avoid any potential conflicts of interest, either real or perceived, in terms of the objectivity of their opinion on the financial statements of the Trust. The policy is subject to annual review and minor revisions (e.g., job titles) were duly considered and approved by the Committee at its January 2024 meeting. The value of non-audit services is routinely disclosed in the Trust's accounts, however there was no such work performed by Mazars during 2023/24.

5. Financial Reporting

At its April and June 2023 meetings the Committee reviewed the draft and audited annual financial statements for 2022/23 before submission to the External Auditor (draft accounts) and NHS England (draft and audited accounts), and we understand these were in agreement with our accounting records and the current Regulatory requirements.

The Committee reviewed and agreed the detailed accounting principles for the 2023/24 accounts at its April 2024 meeting. The Committee also reviewed the draft and audited annual financial statements for 2023/24. The Committee shall also approve the 2023/24 financial statements on behalf of the Trust Board (in line with a request for formal delegated authority to be granted by the Board at its meeting on 13 June 2024, which was approved), which are due for submission to NHSE by the national deadline of noon on Friday 28 June 2024. The Trust Chair and Chief Executive are expected to be in attendance at the June 2024 meeting of the Committee.

At the April 2024 Committee meeting the issue of 'Going Concern' status was discussed. As a result, the Committee endorsed the view that the Trust is a going concern for the purposes of the annual accounting exercise. This was agreed by the External Auditor.

6. Management Reports

The Committee has reviewed various management assurance reports from a range of Directors and managers within the organisation in relation to relevant areas of enquiry during the financial year 2023/24, in line with the Committee's annual work plan and on an ad-hoc basis (e.g. officers to discuss Internal Audit reports). We thank all those who assisted the Committee in these matters.

7. Other Matters Worthy of Note

The Committee followed its agreed annual work plan throughout the year and received regular reports including Waiving of Standing Orders; Losses and Compensations; Hospitality and Sponsorship declarations and Information Governance Reports. Additional information is called for as appropriate.

Throughout the year the Committee also received the minutes from the Trust's main assurance Trust Board sub-committees in order to assess the effectiveness of the Trust's governance arrangements.

Minutes of the Committee's meetings and a Chair's Summary Report of matters to be escalated are submitted to the Trust Board for information, assurance or decision as necessary.

The Committee members would like to place on record their thanks to the Trust's External Auditors (Mazars), Internal Auditors (RSM), and our in-house counter-fraud service. All have provided a professional and effective service during 2023/24.

8. Conclusion and Plans for 2024/25

The Audit, Risk and Governance Committees-in-Common aligned annual work plan for 2024/25 is attached at **Appendix 2**.

The Committees will remain active in reviewing the risks, internal controls, reports of auditors and audit recommendations and will continue to press for action and improvements where required throughout the coming year.

The Audit, Risk and Governance Committees-in-Common will continuously assess its effectiveness to operate as committees-in-common for the benefit of the Group - NHS Humber Health Partnership.

Appendix 1 - Schedule of Attendance at Audit, Risk and Governance Committee meetings 2023/24

Member / Attendee	Apr-23	Jun23	Jul23	Oct-23	Jan-24
Members:					
Tracey Zepherin – NED / Chair (to July 23)	Y	N	N	-	-
Jane Hawkard – NED / Chair (from October 23)	-	-	-	Y	Y
Mike Robson – NED / Vice Chair	Y	Y[1]	Y[1]	Y	Y
Tony Curry – NED	Y	Y	Y	N	Y
Regular Attendees:					
Lee Bond – Group Chief Financial Officer	Y	Y	Y	Y	Y
Suzanne Rostron – Director of Quality Governance	Y	N	N[2]	N	-
Rebecca Thompson – Head of Corporate Affairs	Y	Y	Y	Y	Y
Sally Stevenson - Asst. DoF – Compliance & Counter Fraud	Y	Y	Y	Y	Y
Nicki Foley – Local Counter Fraud Specialist	Y	N[3]	Y	Y	Y
Data Protection Officer and Lead for IT (SM) (from July 23)	-	-	Y	Y	Y
Internal Audit (RSM)	Y	Y	Y	Y	Y
Counter Fraud (RSM) (to April 23)	Y	-	-	-	-
External Audit (Mazars)	Y	Y	N	Y	Y
Group Chief Executive (JL) (from January 24)	-	-	-	-	N
Ad-hoc Attendees:					
Asst. DoF – Planning & Control (NP)	Y	Y	-	-	-
Director of Procurement (EJ)	Y	-	-	Y	-
Head of Freedom to Speak Up (FM)	Y	-	-	-	Y
Chief Executive (CL)	-	Y	-	-	-
Head of Legal (GC)	-	-	Y	-	-
Group Chief Technology Officer (TD)	-	-	Y	-	Y

Member / Attendee	Apr-23	Jun-23	Jul-23	Oct-23	Jan-24
Ad-hoc Attendees continued…					
Head of HR Services (HK)	-	-	-	Y	-
Group Director of IT Performance and Operations (SM)	-	-	-	-	Y
HUTH Trust Vice Chair / Associate NED (SH) (Observer)	-	-	-	-	Y

Notes:

[1] Mike Robson as Chair
[2] Michela Littlewood in attendance
[3] Not required to attend, Final Accounts meeting only

APPENDIX 2

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Audit, Risk & Governance Committees-in-Common Aligned Work Plan 2024 / 25

				Quarter 4 (23 / 24)			Quarter 1 (24/25)			Quarter 2 (24/25)			Quarter 3 (24/25)			Quarter 4 (24/25)			
Agenda Item	**Method of Reporting**	**Report Lead**	**Frequency**	**Jan** **25.1.24**	**Feb**	**Mar**	**Apr** **25.4.24**	**May**	**Jun** **19.6.24** **HUTH Public Disclosure Documents**	**Jul** **25.7.24**	**Aug** **15.8.24** **NLAG Public Disclosure Documents 23/24 only**	**Sep**	**Oct** **31.10.24**	**Nov**	**Dec**	**Jan** **23.1.25**	**Feb**	**Mar**	**Action**
Core Business Items																			
Minutes of the Previous Meetings	Written	Committee Chair	Quarterly	**X**			**X**			**X**			**X**			**X**			Approval
Matters Arising & Action Tracker (management & monitoring of committee actions)	Written	Committee Chair	Quarterly	**X**			**X**			**X**			**X**			**X**			Discussion & Assurance
Review / Self Assessment of Committee Effectiveness	Written	Committee Chair	Annually	**X**												**X**			Discussion & Assurance
Review of Committee Terms of Reference & Work Plans	Written	Committee Chair	Annually	**X**												**X**			Approval
Annual Report to the Trust Board (& Council of Governors for NLAG)	Written	Committee Chair	Annually						**X** **HUTH**		**X** **NLAG**								Approval
Annual Meeting Cycle	Written	Committee Chair	Annually										**X**						Noting
Matters Referred to the Committee																			
Matters referred by the Trust Boards or other Board Committees	Written	Committee Chair	As required	**To be added to the agenda as required**															Discussion
Matters referred to other Board Committees	Written	Committee Chair	As required	**To be added to the agenda / agreed at the relevant meeting as required (and recorded in the minutes & action log)**															Discussion
Committee Specific Business Items																			
Governance, Risk Management and Internal Control (including financial reporting):																			
Board Assurance Framework (BAF) - annual review of adequacy and effectiveness of system for devising and monitoring the BAF.	Written	Group Director of Assurance	Annually							**X**									Assurance
Risk Register - annual review of adequacy and effectiveness of system for the management and monitoring risk.	Written	Group Chief Medical Officer	Annually							**X**									Assurance
Annual Review of Risk Management Strategy / Development Plan Progress Report.	Written	Group Chief Medical Officer	Annually							**X**									Assurance
Review of Board Committees Conduct Risk Oversight including Minutes, Highlight Reports & Action Logs from Board Committees (excluding Remuneration)	Written	Committee Chairs	Quarterly	**X**			**X**			**X**			**X**			**X**			Assurance
Annual Summary of Remuneration Committees Business	Written	Trust Chair	Annually				**X**												Assurance
Public Disclosure Statements:																			
Going Concern Report and Review of Changes to Accounting Policies	Written	Group Chief Financial Officer	Annually				**X**												Discussion & Approval
Draft Annual Accounts & VFM Conclusion	Written	Group Chief Financial Officer	Annually				**X**												Discussion & Approval

Agenda Item	Method of Reporting	Report Lead	Frequency	Quarter 4 (23 / 24)			Quarter 1 (24/25)			Quarter 2 (24/25)			Quarter 3 (24/25)			Quarter 4 (24/25)			
				Jan 25.1.24	Feb	Mar	Apr 25.4.24	May	Jun 19.6.24 HUTH Public Disclosure Documents	Jul 25.7.24	Aug 15.8.24 NLAG Public Disclosure Documents 23/24 only	Sep	Oct 31.10.24	Nov	Dec	Jan 23.1.25	Feb	Mar	Action
Annual Governance Statement	Written	Group Director of Assurance	Annually				X Draft		X HUTH Final		X NLAG Final								Assurance
Audited Annual Accounts (under TB delegated authority if necessary)	Written	Group Chief Financial Officer	Annually						X HUTH		X NLAG								Discussion & Approval
Trust Annual Report (under TB delegated authority if necessary)	Written	Group Director of People	Annually						X HUTH		X NLAG								Assurance
Management Reports for Assurance:																			
Review of Waiving of Standing Orders	Written	Group Chief Financial Officer	Bi-annually				X						X						Assurance
Review of Losses & Compensation (inc. Special Payments & Write-Offs)	Written	Group Chief Financial Officer	Bi-annually				X						X						Assurance
Review of Standards of Business Conduct Declarations	Written	Group Director of Assurance	Bi-annually				X						X						Assurance
Review of Salary Overpayments and Underpayments	Written	Group Chief Financial Officer	Annually				X												Assurance
Review of Legal Fees and External Consultancy Fees	Written	Group Director of Assurance	Annually							X									Assurance
Review of Procurement KPI Data (including invoices without PO's and contracts update)	Written	Group Chief Financial Officer	Annually										X						Assurance
Annual Claims Report	Written	Group Chief Medical Officer	Annually							X									Assurance
Document Control Report	Written	Group Director of Assurance	Bi-annually				X						X						Assurance
Review of relevant external reports, recommendations & assurances, as appropriate e.g. CQC, NHS Resolution, Royal Colleges, accreditation bodies - Summary of who has been to the Trust and the outcome.	Written	Group Director of Assurance	As required	**To be added to the agenda as required**															Discussion & Assurance
Internal Audit:																			
Private discussion with the auditors (Internal & External)	Verbal	Committee Chair / Internal Auditor	As required						X HUTH		X NLAG								Discussion
Annual Internal Audit Plan	Written	Internal Auditor	Annually				X												Assurance
Internal Audit Routine Progress Report	Written	Internal Auditor	Quarterly				X			X			X			X			Assurance
Status Report on Implementation of Internal Audit Recommendations	Written	Internal Auditor	Quarterly				X			X			X			X			Assurance
Head of Internal Audit Opinion Statement	Written	Internal Auditor	Annually				X Draft		X HUTH Final		X NLAG Final								Assurance
Internal Audit Annual Report (including client feedback survey results and review of effectiveness KPIs)	Written	Internal Auditor	Annually						X HUTH	X NLAG									Assurance
Changes to Internal Audit Service Provider	Written	Group Chief Financial Officer	As required	**To be added to the agenda as required**															Approval
External Audit:																			
Private discussion with the auditors (Internal & External)	Verbal	Committee Chair / External Auditors	As required						X HUTH		X NLAG								Discussion
Audit Strategy Memorandum (Audit Plan / Timetable / Fees)	Written	External Auditor	Annually				X												Approval

				Quarter 4 (23 / 24)			Quarter 1 (24/25)			Quarter 2 (24/25)			Quarter 3 (24/25)			Quarter 4 (24/25)			
Agenda Item	**Method of Reporting**	**Report Lead**	**Frequency**	**Jan** **25.1.24**	**Feb**	**Mar**	**Apr** **25.4.24**	**May**	**Jun** **19.6.24** **HUTH Public Disclosure Documents**	**Jul** **25.7.24**	**Aug** **15.8.24** **NLAG Public Disclosure Documents 23/24 only**	**Sep**	**Oct** **31.10.24**	**Nov**	**Dec**	**Jan** **23.1.25**	**Feb**	**Mar**	**Action**
External Audit Routine Progress Report	Written or verbal as appropriate	External Auditor	Quarterly	**X**			**X**			**X**			**X**			**X**			Assurance
Audit Completion Report & Letter of Representation	Written	External Auditor	Annually						**X** **HUTH**		**X** **NLAG**								Assurance
Auditor's Annual Report	Written	External Auditor	Annually						**X** **HUTH**		**X** **NLAG**								Assurance
Annual Review of External Auditor Performance	Written	Group Chief Financial Officer	Annually										**X**						Assurance
Changes to Service Provider (+ support to the Council of Governors - NLaG)	Written	Group Chief Financial Officer	As required	**To be added to the agenda as required**															Discussion
Counter Fraud																			
Annual Counter Fraud Operational Plan	Written	LCFS	Annually				**X**												Assurance
Annual Counter Fraud Report	Written	LCFS	Annually							**X**									Assurance
LCFS Progress Reports	Written	LCFS	Quarterly	**X**			**X**			**X**			**X**			**X**			Assurance
Annual Review of Fraud & Corruption Policy	Written	LCFS	Annually				**X**												Assurance
Results of Staff Fraud Awareness Survey	Written	LCFS	Two Yearly							**X**									Assurance
Emergency Preparedness, Resilience & Response (EPRR)																			
Annual EPRR and Business Continuity Report including Medical Gas Testing Oversight	Written	Group Chief Delivery Officer	Annually							**X**									Assurance
Information Governance (IG) & Cyber Security																			
Annual review of the Trusts' IG & cyber security arrangements *(private agenda item)*	Written	Group Digital Information Officer	Annually							**X**									Assurance
Annual IG Toolkit Return	Written	DPO / Information Governance Lead	Annually							**X**									Assurance
IG Steering Group Highlight Report	Written	DPO / Information Governance Lead	Quarterly	**X**			**X**			**X**			**X**			**X**			Assurance
Systems for Raising Concerns:																			
Annual review of the Trusts' arrangements for Raising Concerns / Freedom to Speak Up (FTSU)	Written	FTSU Guardian	Annually	**X**												**X**			Assurance
Governance & Regulatory Compliance:																			
Compliance with the NHS Provider Licence	Written	Group Director of Assurance	Annually						**X**		**X**								Assurance
Compliance with the NHS Code of Governance	Written	Group Director of Assurance	Annually						**X**		**X**								Assurance
Compliance with the Fit & Proper Persons Test	Written	Group Director of Assurance	Three Yearly				**X**												Assurance
Policy Review																			
Finance Related Policies (SFIs / Standing Orders / Scheme of Delegation / Recovery of Salary Overpayments Policy)	Written	Group Chief Financial Officer	Three Yearly / As Required	**To be added to the agenda as required**															Approval and / or Endorse for Board

				Quarter 4 (23 / 24)			Quarter 1 (24/25)			Quarter 2 (24/25)			Quarter 3 (24/25)			Quarter 4 (24/25)			
Agenda Item	**Method of Reporting**	**Report Lead**	**Frequency**	**Jan** **25.1.24**	**Feb**	**Mar**	**Apr** **25.4.24**	**May**	**Jun** **19.6.24** **HUTH Public Disclosure Documents**	**Jul** **25.7.24**	**Aug** **15.8.24** **NLAG Public Disclosure Documents 23/24 only**	**Sep**	**Oct** **31.10.24**	**Nov**	**Dec**	**Jan** **23.1.25**	**Feb**	**Mar**	**Action**
Annual Review of Policy for Engagement of External Auditors for External Audit Work	Written	Group Chief Financial Officer	Annually	**X**												**X**			Approval
Standards of Business Conduct Policy	Written	Group Director of Assurance	Three Yearly				**X**												
Notes:																			
1. This work plan reflects the core business of the Audit, Risk & Governance Committees-in-Common. Topical / emerging issues will be added to the committees' agenda as required.																			

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)164

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**8 August 2024**
Director Lead	Gill Ponder/Helen Wright, Non-Executive Director Committee Chairs
Contact Officer / Author	Lee Bond, Group Chief Financial Officer
Title of Report	**Capital & Major Projects Committees-in-Common Minutes February 2024 and April 2024**
Executive Summary	Minutes of the meetings held on 20 February 2024 and 23 April 2024 attached for information.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Approved at Committees-in-Common
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

CAPITAL & MAJOR PROJECTS COMMITTEES-IN-COMMON

Minutes of the meeting held on Tuesday, 20 February 2024
9.00am to 12.00pm, Boardroom, Hull Royal Infirmary
For the purpose of transacting the business set out below:

Present:

Core Members:

Mike Robson	Non-Executive Director, HUTH (Chair)
Lee Bond	Group Chief Financial Officer
Tony Curry	Non-Executive Director, HUTH
Gill Ponder	Non-Executive Director, NLaG
Shaun Stacey	Group Chief Delivery Officer

In Attendance:

Ivan McConnell	Group Chief Strategy & Partnership Officer
Alastair Pickering	Chief Medical Information Officer (rep. Group Chief Digital Officer)
Alison Hurley	Assistant Trust Secretary (rep. Group Director of Assurance)
Lynn Arefi	Personal Assistant (Minutes)

Observer(s):

Ian Reekie	Lead Governor, NLaG (Governor Observer)
Sean Lyons	Group Chair

KEY
HUTH - Hull University Teaching Hospitals NHS Trust
NLaG – Northern Lincolnshire & Goole NHS Foundation Trust

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

Mike Robson welcomed those present to the first meeting of the Capital and Major Projects Committees-in-Common meeting and introductions followed.

The following apologies for absence were noted: Simon Parkes, NLaG Non-Executive Director (NED).

1.2 Declarations of Interest

No declarations of interests were received in respect of any of the agenda items.

1.3 To approve the Terms of Reference for the Capital & Major Projects Committees-in-Common (CaMP CiC)

Mike Robson referred members to the HUTH and NLaG CaMP CiC Terms of Reference and sought any comments or queries. Gill Ponder advised that she had several minor points which would be passed on to Alison Hurley for amendment. Lee Bond queried section four which related to the responsibilities of the Committees and whether the capital programme and major projects should be defined further with the associated set financial limits. A discussion ensued and it was agreed that Lee Bond would raise this at the Executive Group Cabinet meeting.

Following further discussion, the Committees received and noted the Terms of Reference, and it was agreed that Alison Hurley would liaise with Gill Ponder and Ivan McConnell to reflect the changes required which included:

- Removal of the Group Chief Clinical Design Officer
- Add a definition of Major Capital & Reconfiguration.

Subject to these changes the Committee were happy to approve the Terms of Reference.

ACTIONS:

- **Lee Bond to discuss whether the capital programme and major projects should be defined in the CaMP Terms of Reference at the Executive Group Cabinet meeting, together with associated financial limits**
- **Alison Hurley to liaise with Gill Ponder and Ivan McConnell to reflect changes required to the terms of reference.**

1.4 **Minutes of the previous meeting**

This was the inaugural meeting of the CaMP CiC therefore there were no previous minutes to review.

1.5 **Matters Arising**

No items were raised.

1.6 **Committees-in-Common (CiC) Action Tracker**

None to Note.

2. MATTERS REFERRED TO THE COMMITTEE

2.1 **Matters referred by the Trust Board(s) or other Board Committees**

None to Note.

3. RISK & ASSURANCE

3.1a **Board Assurance Framework (BAF) - HUTH**

Alison Hurley advised that the BAF report for HUTH and NLaG was now in a new common format. It was noted that although individual Trust reports were included, a Group approach would be under development early in the new financial year. There were no recommendations for any changes to the HUTH BAF at present.

Lee Bond asked if the Committees were to receive the full BAF or only the items relevant to the Committees. Gill Ponder suggested that only the strategic objectives assigned to these Committees would be appropriate to avoid any overlap with other Committees.

3.1b **Board Assurance Framework (BAF) – NLaG**

The BAF for NLaG was received and noted with no recommendations for changes.

With reference to Lee Bond's earlier query, the Committees requested that the whole BAF be attached as an appendix for information with only the CiC specific BAF items on the agenda. The Committees agreed that consistency across the BAF's would be required to ensure alignment.

Following various queries and a discussion it was agreed that the disparity of the risk scores between HUTH and NLAG in relation to estates and facilities, finance and digital infrastructure should be reviewed and harmonised.

- *The disparity of the estates and facilities, finance and digital infrastructure issues risk scores to be reviewed and harmonised*
- *The complete BAF to be added to the agenda as a standing agenda item for information.*

3.2 **Risk Register Report**

It was noted that work is ongoing to align the Risk Register across the Group and Alison Hurley advised that a revised report was expected for the next meeting.

3.3 **Proposed Business Cases, Investments & Dis-investments**

3.3.1 **New Build at Hull Royal Infirmary (HRI) - HUTH**

Lee Bond referred the Committees to the circulated report and provided an overview of the proposal for a new build on the Hull Royal Infirmary (HRI) site. This would accommodate a number of priorities including Paediatric Day Surgery recovery, establish a Command Centre, address the displaced accommodation from the Interventional Radiology Theatre (IRT) for development on the second floor together with the relocation of therapies to the third floor. The changes would also facilitate a future development zone in a clinical environment on the second floor. This was noted as a critical path to allow for the expansion of other services.

Tony Curry queried whether this was part of a broader plan for the site or an expediency to resolve particular issues. Lee Bond confirmed that it was a response rather than a long-term estates strategy which would also provide additional space within the Tower Block. Ivan McConnell concurred and provided an overview of the required refurbishments and confirmed that business cases were being drafted in support of this.

Following a discussion, Lee Bond informed members that a business case would be provided for the April meeting.

The Committees were asked to approve:

- Commencement of detailed designs and surveys
- Commencement of the tender process to ensure the construction could commence as soon as possible into the new financial year.

The HUTH CaMP Committee received and noted the presentation and approved commencement to the next stage.

ACTIONS:

- **Business case to be presented to the April meeting on the New Build at Hull Royal Infirmary (HRI) - HUTH**

Replacement of Suite 22 at Castle Hill Hospital - HUTH

3.3.2

The presentation outlined the Reinforced Autoclaved Aerated Concrete (RAAC) within Suite 22 at Castle Hill Hospital (CHH) and the demolition due during February 2024. It was noted that training and development activities had required cancellation due to the lack of this facility, and every effort was made to accommodate courses in other rooms available across both CHH & HRI where possible. Although £1million of capital funding had been received, it was confirmed this would need to be spent within the next 5 weeks and additional funding would also be required.

Lee Bond advised that following discussions with the training and development staff, it was clarified that 50% of the training would need to be on-site which influenced the options available. The area proposed to accommodate training and development would be the unused basement (under the croft), of the new Day Surgery Unit, which is option 1 within the presentation.

- A discussion took place about the need to secure additional capital funding, the impact the national elections may have and Lee Bond informed members that there may be the ability to be flexible to move capital commitments in 2025/26 if required. Positive discussions with NHS England around accessing slippage from the national RAAC monies in 2024/25 was also noted.

Shaun Stacey queried the £2.5million 'fit out' cost and Lee Bond confirmed this was based on the current tenders. A discussion ensued about the level of daylight and the temporary facilities being used.

In response to a query from Tony Curry about whether the impact of the cancelled training sessions was known, Lee Bond confirmed this would be addressed as a compliance issue at the Workforce, Education and Culture CiC.

Lee Bond then sought Committees approval for the following recommendations:

- To progress Option 1 as the most cost effective, timely, and least disruptive option
- To approve the financial risk with the shortfall in current capital funding of £1.5million
- To include the training facility replacement in the 2024/25 capital plan as an over-commitment against plan, and to seek funding in-year as a noted risk.

Mike Robson thanked Lee Bond for the detailed presentation which had been helpful for the Committee to gain a detailed understanding.

The HUTH CaMP Committee agreed to approve the plans to proceed to the next stage of the training facility replacement and approved in principle the over-commitment to the capital programme (£1.5mil), which was noted as a manageable risk.

3.4 **Capital Contract Approvals**

3.4.1 **Day Surgery Phase 2 & 3 Fit Out CHH - HUTH**

Lee Bond took the report as read and outlined the development provided additional theatre capacity at the Castle Hill site, allowing the existing two day case theatres at HRI to be re-provided in modern facilities. The net increase in day case capacity would facilitate a more efficient model and free up valuable inpatient theatre capacity as adult day case work is repatriated to the day case theatres. This would also support 52/104 week waits, the Cancer pathway and day case numbers.

It was noted that six contractors had been approached and tender returns were due mid-February 2024. Pre-tender estimates had been completed for each phase based on current market rates. The lowest tenders received totalled £5.5million, which was the cheapest option from contractors HELIX.

The HUTH CaMP Committee confirmed agreement to approve once the tender returns have been evaluated. This was to ensure orders are committed in March 2024 to mitigate the key risks of lead-in times and Capital Revenue Limit (CRL) for the 2023/24 financial year.

3.4.2 **Day Surgery Car Park CHH - HUTH**

Lee Bond took the report as read and informed the Committee that this had already been approved and signed off by the Group Chair, Group Chief Executive and was presented to the Committee for retrospective approval.

Gill Ponder queried if the Trust had sought testimonials as part of the quality and evaluation of the contractors. Lee Bond confirmed that all relevant checks are carried out and the Trust had worked with this contractor previously.

In response to a query from Sean Lyons, Lee Bond confirmed that an additional 100 parking spaces would be available.

The HUTH CaMP Committee received the report and approved the quotation as submitted by Ashcourt Demolition Ltd in the sum of £1,078,083 including VAT.

3.4.3 **Theatre 7 & Plant Room Hull Royal Infirmary - HUTH**

The Committee was referred to the report and Lee Bond provided a brief overview. It was noted that one of the critical risks on the HUTH estates risk register was the HRI trauma theatres and this was a continuation of the backlog maintenance (BLM) rolling refurbishment programme for the trauma theatres. The report noted the £3.1million requested to award the contract to Johnson Construction and pre-buy materials.

Gill Ponder queried the low contingency of £50k and Lee Bond advised this was not a huge risk and was expected to be managed within budget.

Lee Bond confirmed that a full evaluation would be carried out by the team in respect to changing the chiller manufacturer and any potential risks in response to a query from Gill Ponder.

The HUTH CaMP Committee received and noted the report. The competitive tender as submitted by Johnson Construction for the refurbishment of Theatre 7 and the build of phase 1 plant room 2 in the sum of £3,174,458.33 including VAT (20%), was approved by the HUTH CaMP Committee.

3.4.4 **North Lincs (NL) Community Diagnostic Centre (CDC) Fit Out & Materials - NLaG**

Lee Bond took the circulated paper as read and outlined the key points. Approval was sought to award the North Lincs CDC Fit out Tender to Helix CMS subject to final re-negotiation to ensure value for money was achieved. The tender review covered the initial tender cost and the reconciled tender sums. Lee Bond confirmed that the budget for the North Lincs CDC would be managed within a surplus from the NEL CDC scheme following a query from Mike Robson.

Gill Ponder queried the safe storage of equipment and Lee Bond confirmed that had been addressed and was not expected to be required for a long period. Ivan McConnell concurred and advised that storage facilities had already been identified.

The NLaG CaMP Committee received and noted the report and approved the North Lincs CDC Fit out Tender being awarded to Helix CMS subject to final re-negotiation to ensure value for money was achieved.

3.4.5 **North East Lincs (NEL) CDC Fit Out & Materials - NLaG**

The report was taken as read and Lee Bond advised that approval was sought to award the NEL CDC Fit out Tender in principle to Morgan Sindall subject to final re-negotiation to ensure value for money is achieved. Final approval would be sought at the April CaMP CiC meeting. Lee Bond advised that it was proposed to seek approval to increase the demolition budget by £750k plus VAT as part of the enabling contract which will be used to purchase more materials, the demolition budget was noted as relatively small. Formal approval would be sought at this Committee at a later date, once the manufacturing and engineering (M&E) details are in place.

Tony Curry asked if there were any associated risks and Lee Bond confirmed there was very little risk with this. Lee Bond added that he would not recommend signing the contract with Morgan Sindall at this point in time until the Trust were confident with the M&E position. Ivan McConnell supported this position and provided an overview of work underway at Freshney Place in Grimsby.

The NLaG CaMP Committee received and noted the report and approved the Committal of £900,323.45 (of material pre-procurement under the enabling contract to mitigate lead-in times and meet CRL limit. The tender award to Morgan Sindall with the constraints noted was also approved in principle.

ACTIONS:

- **Contract to be presented to the April meeting on the North East Lincs CDC Fit Out & Materials – NLaG**

3.4.6 **Grimsby CDC Lease - NLaG**

The circulated CDC report for a 10-year lease was presented to the Committee for information. The report was noted as being approved at the Trust Board meeting in February 2024.

3.5 **Review & Evaluation of Existing Business Cases**

None to note.

3.6 **Review of Relevant External & Internal Audit Reports & Recommendations & Assurance as Appropriate**

None to note.

3.7 **Review of Relevant External Reports, Recommendations & Assurance as Appropriate**

None to note.

Review Assured, escalate or additional information requested.

The Committee agreed that the following would be included within the highlight report to the Trust Board:

- **Board Assurance Framework (BAF)** – the committees were concerned about the disparity of the risks in relation to estates and facilities, finance and digital infrastructure issues and requested that these risks be aligned for NLaG and HUTH
- **Estates Strategy** - the committees sought additional assurance on when the consolidated Estates Strategy would be established
- **Overall lack of capital** - especially in relation to the risks on estates, facilities and infrastructure.

At 10.40am a break ensued for 10 minutes

4. COMMITTEE SPECIFIC BUSINESS ITEMS

4.1 Monthly Capital Finance Report (NLaG/HUTH)

Lee Bond summarised the circulated monthly Capital Finance Report which provided the forecast capital spend for the financial year 2023/24, for both Trusts. Key points highlighted were the transfer of £3.8million from NLaG to HUTH, fully repayable in 2024/25 and the underspend on the CDC at NLaG. The Group capital position was noted on page two of the report and included the forecast to deliver the Integrated Care System (ICS) Capital Control Total of £39.7million and the overall Capital Departmental Expenditure Limit (CDEL) position which will be underspent by £4.7million due to slippage in the CDC scheme in Scunthorpe.

Gill Ponder queried the recurring behaviour to rapidly spend capital in quarter four before the year end and what could be done to break this cycle. Lee Bond confirmed that had been much improved this year apart from the CDC budget, which had caused difficulties. Looking at plans for next year Lee Bond added that he was more hopeful the Group may continue this improved approach for the quarter four period.

Sean Lyons asked if there had been any benefits from being a Group this financial year with having a larger amount of projects and funding. Lee Bond advised the key benefit was the ease of moving funding across the respective Trusts and other learning was ongoing.

Sean Lyons then referred to the potential underspend which had been discussed at previous meetings and queried whether the reasons for this underspend had been identified. Lee Bond advised that there were several reasons which included the capital team not having the necessary skill set or grip on the whole scheme. Lee Bond added that he would like to think lessons had been learnt moving into the new financial year.

Mike Robson acknowledged that the report had been very helpful and thanked Lee Bond and the team for progressing the Group to this position.

4.2 Draft Capital Plan 2024/25 (NLaG/HUTH)

Lee Bond referred the Committees to the previously circulated report and proceeded to provide an overview of the contents. The draft capital programme was highlighted for NLaG on page three which totalled £32million and for HUTH on page four which totalled £35million.

Lee Bond noted all is subject to change as the Group approached year end and risks and competing priorities would need to be managed. The biggest "unknown" and therefore the biggest single risk from a capital perspective at present, was noted as the Electronic Patient Record (EPR). A further risk with the capital programme was the Section 2 agreement of £12million with Hull City Council was not yet agreed. Work continued but was not yet transacted.

Gill Ponder queried if funding for urgent roof repairs had been allocated and Lee Bond confirmed £400k had been set aside within building, maintenance and compliance. However, if a competing priority came along then the roof work may slip but at present the roof repairs were noted as a priority.

Sean Lyons referred to the "spend to save" approach and queried whether this was an opportunity for the Group to ask staff for incentives to save in a consistent, systematic and measured way. Following a discussion Shaun Stacey agreed to take the lead on this along with Ivan McConnell and Lee Bond to explore an "invest to save" scheme for front line staff.

ACTION:

- **Shaun Stacey to lead on exploring an Invest to Save scheme for front line staff.**

Review Assured, escalate or additional information requested.

The Committees were generally assured about the management of the Capital programme, both in the current financial year and the coming financial year. However, the Committees were concerned about the Capital plan risks associated with the Digital Plan Delivery (including the outline business case (OBC) for the electronic patient record (EPR)).

5. MAJOR SERVICE CHANGE / TRANSFORMATION

5.1 Humber Acute Services – Capital Update

Ivan McConnell took members of the Committees through the presentation which provided an update on the Humber Acute Services (HAS) programme and set out an indicative timeline for decision-making following public consultation. The report also provided an overview of the capital requirements for the Trust to deliver the proposed changes. It was noted that finalisation of capital requirements is subject to post-consultation decision making.

Ivan McConnell noted that the anticipated capital funding requirement to deliver the HAS decision making business case (DMBC) was £10.04million (including backlog maintenance). Following a discussion, it was confirmed that this applied to an average of 6.2 patients per day.

Sean Lyons queried any expected impact of local elections and Ivan McConnell confirmed appropriate capacity was in place and no issues were anticipated to date.

The Committees received and noted the report and Mike Robson thanked Ivan McConnell and the team for the good progress to date.

5.2 **Community Diagnostic Centre (CDC) Programme**

The presentation was addressed by Ivan McConnell who advised that he had been asked by the Group Chief Executive to take on the overarching Senior Responsible Officer role for the CDC programme. The presentation provided an overview of the current CDC builds with key milestones and risks. It was noted that the Group needed to ensure the capacity and demand levels expected were appropriate and achievable as it moved forward.

Ivan McConnell noted associated risks for the Group with assumed activity levels from the "go live" date and advised the revenue position would change if the levels were not achieved. The Group would also need to be mindful of the staff training period.

Lee Bond referred to the Capital Investment Board meeting which took place the day before, where the Digital team flagged up the on-going requests for support to these services and suggested to Ivan McConnell that this be addressed.

Lee Bond advised the Committees that there was a requirement for the CDC to be up and running by 1 October 2024 (NLaG) and 1 March 2025 (HUTH), and there was a considerable amount of risk with the requirement to deliver 90% of activity to remain within the confines of the model.

Gill Ponder queried whether this was a greater risk than expected and both Lee Bond and Ivan McConnell confirmed it was very aspirational adding there had also been constant changes to the policy etc., which added challenges in relation to staffing requirements and recruitment. Sean Lyons confirmed the need for pragmatic plans to maximise the approach and output.

Review Assured, escalate or additional information requested.

The Committees noted they were assured about:

- the HAS programme and progress with the consultation
- the management of the CDC programme

The Committees agreed the following risks would be escalated to the Trust Board:

- Build Risks
- East Riding Community Hospital
- Workforce Recruitment Risk
- Revenue Risk

6. DIGITAL

6.1 **Digital Plan Delivery Bi-monthly Update**

Alastair Pickering referred members to the Digital Plan Delivery report and noted that the Digital Programme was currently delivering three critical projects across the Group:

- The PAS migration to a single Lorenzo system
- Implementation of the Badgernet Maternity system across all sites
- Phase one of the Data warehouse upgrade at NLaG.

It was highlighted to the Committees that migration of the Patient Administrative System (PAS) to LORENZO was currently in "full flight". Critical meetings were underway to ensure no live operational or clinical challenges would impact on the continuation of the 'go live' date and safe progress was made. The main area of risk from the PAS migration was noted as the switch off of the LORENZO system at HUTH for approximately 9 hours. Although digital and administrative teams would support all hospital sites from the 'go live' position with a three-week live support programme in place. Alastair Pickering added that he was confident with the plans and have mitigated the reduction in activity.

The maternity system go live across sites would take place in the following weeks.

It was noted that the electronic patient record (EPR) outline business case would be completely reviewed with the addition of new costings. This would be presented to the Capital Investment Board and brought to the CaMP CiC for assurance and information.

Mike Robson thanked Alastair Pickering for the comprehensive update.

Review Assured, escalate or additional information requested.

The Committee were assured with the progress made with the Digital Plan Delivery which was noted as "impressive".

7. HIGHLIGHT REPORTS FROM SUB-GROUPS

7.1 **Capital Resource Allocation Committee Meeting Minutes – HUTH - January 2024**

The HUTH CaMP Committee received and noted the Capital Resource Allocation Committee minutes (HUTH) from January 2024.

7.2 **Capital Investment Board Meeting Minutes - NLaG - January 2024**

The NLaG CaMP Committee received and noted the Capital Investment Board minutes (NLaG) from January 2024.

8. ANY OTHER URGENT BUSINESS

8.1 **Any Other Urgent Business**

No other urgent business was raised.

9. MATTERS TO BE REFERRED BY THE COMMITTEES

9.1 **Matters to be Referred to other Board Committees**

Escalation to other Board Committees was as discussed within the meeting.

9.2 **Matters to be Escalated to the Trust Boards including any proposed changes to the BAFs.**

Matters to be escalated to the Trust Board were as per discussions and agreement within the meeting.

10. DATE AND TIME OF THE NEXT MEETING

Date and Time of the next Capital & Major Projects CiC meeting:

Tuesday, 23 April 2024
9.00am Boardroom, HRI

Mike Robson closed the meeting at 12.05pm and thanked members for their contributions and valid discussions.

Cumulative Record of Attendance at the CaMP CiC 2024/2025

		2024					
Name	**Title**	**Feb**	**Apr**	**Jun**	**Aug**	**Oct**	**Dec**
CORE MEMBERS							
Gill Ponder	Chair / Non-Executive Director (NED - NLaG)	Y					
Mike Robson	Chair / Non-Executive Director (NED - HUTH)	Y					
Lee Bond	Group Chief Financial Officer	Y					
Tony Curry	NED (HUTH)	Y					
Simon Parkes	NED (NLaG)	Y					
Shaun Stacey	Group Chief Delivery Officer	Y					
VACANT	Group Chief Clinical Design Officer	N					
Quoracy: *three of five core members (inc.one of two Trust NEDs, two Group Executive Directors or appointed deputies)*							
REQUIRED ATTENDEES							
VACANT	Group Director of Estates	D					
VACANT	Group Director of Transformation	N					
VACANT	Group Chief Digital Information Officer	D					
VACANT	Group Director of Assurance or deputy	D - AH					
Alison Drury	Deputy Director of Finance (HUTH)	Y					
Ivan McConnell	Group Chief of Strategy & Partnerships	Y					
Ian Reekie	Governor Observer (NLaG)	Y					

DESIGNATED DEPUTIES	
Executive Director CiC member	**Designated Deputies**
Lee Bond Group Chief Financial Officer	Deputy Chief Financial Officer – vacant, covered by: Alison Drury, Deputy Director of Finance (HUTH) Brian Shipley, Deputy Director of Finance (NLaG) Steve Evans, Operational Director of Finance (HUTH)
Ivan McConnell Group Chief of Strategy & Partnership	Adam Creeggan, Group Director of Performance
Shaun Stacey Group Chief Delivery Officer	Ashy Shanker – Managing Director - South Bank Neil Rogers – Managing Director - North Bank
Vacant Group Chief Clinical Design Officer	TBC

KEY: ***Y*** *= attended* ***N*** *= did not attend* ***D*** *= nominated deputy attended* *= position vacant*

CAPITAL & MAJOR PROJECTS COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on 23 April 2024
9.00am to 12.00noon Boardroom, Hull Royal Infirmary

For the purpose of transacting the business set out below:

Present:

Core Members:

Gill Ponder	Non-Executive Director, NLaG (Chair)
Lee Bond	Group Chief Financial Officer
Tony Curry	Non-Executive Director, HUTH
Simon Parkes	Non-Executive Director, NLaG
Mike Robson	Non-Executive Director, HUTH
Shaun Stacey	Group Chief Delivery Officer

In Attendance:

Alex Best	Interim Group Deputy Director of Capital Services
Linsay Cunningham	Deputy Director of Strategy (rep Group Chief of Strategy)
Alison Hurley	Deputy Director of Assurance
Alastair Pickering	Chief Medical Information Officer (rep Group Chief Digital Officer)
David Sharif	Group Director of Assurance
Lynn Arefi	Personal Assistant (Minutes)

Observer(s):

Julie Beilby	Associate Non-Executive Director, NLaG
Stuart Hall	Non-Executive Director, HUTH
Ian Reekie	Governor Observer (NLaG)

KEY
HUTH - Hull University Teaching Hospitals NHS Trust
NLaG – Northern Lincolnshire & Goole NHS Foundation Trust

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

Gill Ponder welcomed those present to the meeting as the Committee Chair. The following apologies for absence were noted: Ivan McConnell and Andy Haywood. It was also noted that Stuart Hall was not a core Committee member and was attending the meeting as an observer.

1.2 Declarations of Interest

No declarations of interests were received in respect of any of the agenda items.

1.3 **To approve the minutes of the meeting held on 20 February 2024**

The minutes of the meeting held on 20 February 2024 were accepted as a true and accurate record.

1.4 **Matters Arising**

Gill Ponder invited Committee members to raise any matters requiring discussion not captured on the agenda. No items were raised.

1.5 **Committees-in-Common Action Tracker**

The following updates to the Action Tracker were noted:

1.3 - Terms of Reference (ToR) - Closed - on agenda
3.1b - Board Assurance Framework - Closed - picked up within the highlight report
3.3.1 - New Build at Hull Royal Infirmary (HRI) - Closed – short form business case on the agenda
3.4.5 - North East Lincs Community Diagnostic Centre (CDC) Fit Out & Materials (NLaG) - Closed - this contract was on the agenda
4.2 - Draft Capital Plan - Closed - Shaun Stacey advised that various options were being explored and following the previous meeting the waiting list management IT tool and bed management tool schemes had been reviewed. Several Trusts were using the bed management tool and it was noted that confirmation of funding was required from NHS England (NHSE). An update would be provided for the Committees in approximately four months' time. It was agreed to close this action as the Committees would receive the appropriate updates as and when they were due.

1.6 **Terms of Reference – Final**

The Terms of Reference (ToR) were received by the Committees for approval and Gill Ponder sought any comments. Lee Bond noted that 5.2.1 refers to the Group Director of Estates in the attendance section and suggested that as the Group had not appointed to this post it be replaced with the Deputy Director of Estates and Capital, which was currently being covered by Alex Best.

Gill Ponder requested the Group Chief Clinical Design Officer referred to in section 5.1.4 be removed as this post had been removed from the Group Executive structure. Appendix A also to be amended to "NLaG" and not "HUTH" in the NLaG ToR.

Gill Ponder queried the capital limit which the Committees could approve and Lee Bond confirmed this would be in line with the Scheme of Delegation as referred to in the ToR. It was noted that a revised Scheme of Delegation would be presented to the Group Cabinet and then the following Audit Committees for ratification.

The Committees received, noted and approved the Terms of Reference subject to the minor changes noted.

Julie Beilby referred to section 6.7.1 around the publication of papers which should be five clear working days prior to the meeting and queried whether this was normal practice. Gill Ponder confirmed it was and advised that any late papers would be captured in the highlight report in response to a query from Stuart Hall. Simon Parkes agreed that timely circulation of papers was essential, and his understanding was better arrangements had been established but suggested it still required raising at the Non-Executive Director (NED) meeting.

***ACTION**:* Late circulation of papers for Committees-in-Common to be discussed at the next Chair/NEDs meeting.

2. MATTERS REFERRED

2.1 Matters referred by the Trust Board(s) or other Board Committees

Gill Ponder reported that no matters had been referred by the Trust Board for consideration by the Committees.

3. RISK & ASSURANCE

3.1 Board Assurance Framework (BAF)

3.1a It was noted that the HUTH BAF would be referred to in item 10.1 – Complete Board Assurance Framework later in the agenda.

3.1b It was noted that the NLaG BAF would also be referred to in item 10.1.

3.2 Risk Register Report

Gill Ponder noted that there was no written report and asked David Sharif to provide an update. David Sharif noted the Risk Register Report was part of the ongoing Group harmonisation work being undertaken and was work in progress. It was hoped that a refreshed Trust Strategy would be available by June or July which would progress to determine the strategic risks and then align the high-level risks to the appropriate committees. David Sharif noted the good work in progress and confirmed a summary report would be presented to future Committee meetings.

Simon Parkes suggested this should be referred to the Audit Committees as it affected all committees and it felt very uncomfortable that it had been several months since discussion around the Risk Register had taken place. As a NED and Joint Chair of the Audit, Risk and Governance (ARG) Committees-in-Common (CiC) he was concerned about the lack of oversight this presented and suggested that a view should be taken on what impact that may have on the overall scheme of assurance. Gill Ponder concurred. It was noted that as the next AR&G CiC meeting was not until July an interim response would be provided. The review requested would include consideration of the assurance gap with the Committees not having recent sight of the Risk Register and to what extent any gap was mitigated by other arrangements including the Group Cabinet Risk and Assurance Committees.

David Sharif informed members that high-level risks would be presented to the next meeting and Committees should be relatively assured this was being addressed.

ACTION: Risk Register to be referred to the ARG CiC for a response on any assurance gap found, in advance of the July 2024 meeting.

3.3 **Review of Relevant External & Internal Audit Report(s) & Recommendation(s)**

There were no external or internal audit reports or recommendations to note.

3.4 **Review of Relevant External Report(s), Recommendations & Assurances**

There were no external reports, recommendations or assurances to note.

Review The Committees confirmed that the Terms of Reference had been approved and the referral of the Risk Register to the Audit, Risk and Governance Committees-in-Common was noted.

4. COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 **Group Capital Finance Report (NLaG and HUTH) Month 12**

Lee Bond referred to the Group Capital Finance report and advised the figures were subject to audit. The report provided the final capital spend for the financial year 2023/24, for both Trusts. Year-end Group capital spend totalled £108 million which was in line with the resource approved throughout the year. A slight variance across the organisations was referred to which was in order to manage the overall resource. Key points to note were the transfer of £3.8 million from NLaG to HUTH, repayable in 2024/25. The £4 million Public Dividend Capital (PDC) related to the underspend on the Community Diagnostic Centres (CDC) at NLaG and had been deferred to 2024-25, which meant the Capital Departmental Expenditure Limit (CDEL) in 2023-24 had been maximised, mitigating the risks into 2024-25.

Lee Bond drew the Committee's attention to the major capital spends for HUTH and NLaG in year and noted that the CDC North Bank scheme for £12 million for NLaG was not referenced within the report as this had been paid direct to the Council. Lee Bond added that the Trust had maximised the allocation with no significant underspend which was a positive.

Simon Parkes queried the basis of re-allocation of money across the Trusts. Lee Bond confirmed that the money was held at an Integrated Care Board (ICB) level and each Trust applied to under-spend or over-spend as required, it was noted that this caused no account issues.

In response to a query from Tony Curry, Lee Bond confirmed that there was an underspend with Electronic Patient Records (EPR) and funds had been brokered to the Centre, which would be received back and although this was being

managed it was not an easy task. It was agreed to circulate a schedule which would show the balances and spend to date. Simon Parkes took the opportunity to thank Lee Bond and his team for the work undertaken on the control total.

ACTION: Lee Bond to circulate the Electronic Patient Records (EPR) spend schedule.

Simon Parkes queried the arrangements for accountability of the money the Council were spending and how assurance would be received. Lee Bond advised that he had met with the Capital Lead from the Council and the Section 151 Officer as it had been felt that the Estates Capital team had been kept a little at "arm's length". It had now been agreed that the Group's Capital team and the Council's team will work openly and transparently going forward and be jointly managed. Lee Bond confirmed that some risks would still be retained but close working would continue with the Council and the contractors. Simon Parkes noted that warranties could be problematic if there were sub-contractor failure which could pose an area of risk.

Review Gill Ponder thanked everyone for their input and noted the Committees were assured that the Group Capital programme had been delivered for 2023/24 and that the Capital Departmental Expenditure Limit (CDEL) had been achieved, but noted that £4.0m of Public Dividend Capital (PDC) relating to the underspends on the Community Diagnostic Centres (CDCs) had been deferred to 2024/25 and that £3.8m had been transferred from NLaG to HUTH, which would be repaid in 2024/25. Areas of risk identified on the Council and the risk arrangements and warranty oversight would be captured in the Trust Board highlight report.

4.1.1 **Draft Capital Programme 2024/25 (NLaG and HUTH)**

Lee Bond presented the Draft Group Capital Programme for 2024-25 and noted little change since the previous meeting. Depreciation for 2023/24 was noted as £40 million with the capital programme being £71 million. This will continue to reduce with the completion of the Acute Assessment Unit (AAU) and the Emergency Department (ED) at DPoW.

The report provided the updated draft Capital Programme for 2024/25, along with expected Integrated Care Service Capital Control Totals. Key points to note were the previously reported shortfall to complete the CDCs at NLAG was resolved due to the £4 million Public Dividend Capital (PDC) funding from 2023-24 being carried over to 2024/25. The remaining allocations in the Capital Programme were to address the backlog maintenance issues, aged equipment replacement and the IT infrastructure, along with allocations associated with the Electronic Patient Record (EPR) Business Case, which would be revised due to affordability issues. A risk was noted that the EPR funding could not be spent in 2024/25 and a request had been submitted to defer it until 2025/26 to allow time for a contract to be awarded and further funding to be secured.

A discussion took place around the risks of insufficient capital being available to complete all planned schemes in year due to a lack of contingency reserves and a potential risk arising from the validity of warranties where CDC funds had been transferred to Hull City Council, who would then place contracts with Sub-Contractors.

Mike Robson queried when the Capital Programme would be signed off and Lee Bond confirmed it formed part of the Annual Planning process which had been presented in draft to the Trust Boards-in-Common.

Lee Bond responded to a query from Mike Robson and advised that there had not been much inclusion in the report on the "Net Zero 30" at the end of the last financial year but additional allocations had now been received to address lighting improvements etc., and there was a boiler replacement planned for SGH (with designs planned in 2024/25 rather than implementation). It was also noted that every new building was "net zero".

Alastair Pickering informed members that grant funding would be applied for in-year which did not require a Group contribution and would support the move to net zero in all approaches.

Review Gill Ponder summarised that the report was endorsed by the Committees for Trust Boards-in-Common approval which would be captured in the highlight report.

4.2 **Review & Evaluation of New Business Cases, Investments & Dis-investments within Delegated Limits and/or Endorsement for Trust Board Approval**

4.2.1 **New Build at Hull Royal Infirmary (HRI) HUTH**

Lee Bond introduced the business case noting that this was a nationally prescribed short-form business case based on value. As part of background to the business case, Lee Bond advised that HUTH's estates strategy was to progressively empty the tower block from the top down with a view to securing funding for additional wards, then the tower block would be utilised solely for administration and office space. Due to bed pressure, the 13th floor of the tower block was developed into a Discharge to Assess facility which left the Trust with no permanent solution for administrative staff accommodation which remained an issue.

The business case outlined the proposal to create a new three storey modular build on the HRI site, adjacent to the Women & Children's hospital to address several current capacity issues. It was proposed that this new modular block would accommodate the following services:

- Paediatric day surgery admissions, second stage recovery/discharge, play area and consultant rooms to facilitate the move of Paediatric Day Surgery into the Women's & Children's Hospital (W&CH)
- The establishment of a Well Being Centre on the HRI site
- Office accommodation for the Emergency Department (ED) consultants and the Trauma & Research Network Team (TARN) who were displaced due to IRT 4 scheme
- The establishment of a Command/Control Centre for Operational/Bed Management, including accommodation for the Discharge Team, Transport Team and Social services teams.

The costs of the new development were included within the Trust's capital programme (£4.2 million) although some associated works were required to the adjacent W&CH building to ensure that the patient pathway remains safe, with appropriate first and second stage recovery. If the current planning application was supported, it would enable a speedy major development and the £300,000 revenue costs would predominantly increase due to domestic and utility charges.

Simon Parkes queried the ground assessment as there appeared to be little contingency and no "optimism" bias included and also asked whether conversations were being held with the PFI provider. Lee Bond confirmed confidence in the costs and advised there were no current issues or concerns with the ground as the Allam Suite had recently been built on the adjacent land with no issues, although less confidence was noted with the costs within the PFI building. A discussion about the links between the buildings ensued.

Tony Curry noted the extent of office accommodation and queried whether the Group Cabinet had agreed this as a high priority. Lee Bond confirmed that this would be presented to Group Cabinet shortly. Shaun Stacey confirmed full support of the paper and its priority from an operational perspective as it contributed to elective service improvements and addressed the need for a robust Command Centre.

In response to a query from Simon Parkes about the extent of the control centre costs reflected in the business case, Lee Bond advised that the national Business Continuity Management Strategy (BCMS) programme had been paused and this operating system would be added to the facility once the programme pause was lifted. The business case did include funding for screens etc., but the main operating system would be funded through BCMS.

Julie Beilby referred to office accommodation versus clinical accommodation and asked if alternatives for office accommodation had been investigated. Lee Bond advised this had been considered previously but no alternative options had been available.

Review Gill Ponder noted that the HUTH Committee had heard the "case of need", supported the continuation of the planning application with associated costs and agreed the Business Case would require approval by the Group Cabinet, before re-presentation for approval at the June CaMP CiC meeting.

4.3 **Review & Evaluation of Existing Business Cases**

There were no existing business cases for the Committees to note.

4.4 **Post Capital Project Evaluation**

There were none for the Committees to note.

4.5 **Capital Contract Approvals**

4.5.1 **North East Lincs CDC Fit Out & Materials – NLaG**

Lee Bond took the paper as read and confirmed the paper sought approval to appoint Morgan Sindall Construction and Infrastructure Ltd to undertake the internal fit out construction works to the CDC 'Spoke' in Grimsby Town Centre within the Freshney Place Shopping Centre, which was currently owned by North East Lincolnshire Council. This scheme was an integral part of the Integrated Care Services (ICS) programme of community diagnostic service developments. The CDC spoke was being constructed within the space of five existing shop units and would provide imaging (X-Ray, Ultrasound and DEXA), physiological measurement and pathology.

Alex Best outlined that the Shared Business Services (SBS) Framework was utilised to source a Principal Contractor for the works on a two stage 'open book' basis. Morgan Sindall was selected through the SBS Procurement Process and appointed to undertake the Enabling Works package. This included site establishment (hoardings), soft strip and the demolition works needed to clear the existing shop units and dividing walls thereby enabling the five units to be combined into one facility. Morgan Sindall had now priced the construction and fit-out elements of the project, which were scheduled to commence on 29 April 2024 with construction work for the CDC due for completion by 30 September 2024 and a clinical start date of 13 October 2024.

Alex Best noted the current cost plan incorporated actual figures for enabling works. Morgan Sindall tendered figures for the main fit-out works, identified savings and indicated a surplus of available funding over forecast cost which left a contingency of circa £160,000. The NLaG Committee was asked to recommend Board approval be granted to appoint Morgan Sindall to undertake the internal fit-out inclusive of all building, mechanical and electrical construction works for the sum of £6,131,903.20 inclusive of VAT.

Lee Bond advised that the £0.5 million "variations" within the report was a form of contingency in response to a query from Gill Ponder.

The Committee received, noted and endorsed the North East Lincs CDC Fit Out and Materials report to be presented to the next Trust Boards-in-Common for formal approval.

4.5.2 **Castle Hill Day Surgery Unit (DSU) Phase 2 & 3 – HUTH**

It was noted that this report had been to the Trust Boards-in-Common for approval and was presented at this meeting for information only.

Review To include the Committees were assured but noted risks in relation to the Capital Plan. The Capital Programme 2024/25 was endorsed for the Trust Boards-in-Common approval. The New Build at HRI planning application was supported in principle by the HUTH Committee, but required approval from Group Cabinet prior to presentation back to this Committee for formal approval. The North East Lincs CDC Fit out contract was endorsed for Trust Boards-in-common approval.

At 10.40am the Committees undertook a short break.

5. Major Service Change / Transformation

5.1 Humber Acute Services Review (HASR)

Gill Ponder welcomed Linsay Cunningham, Deputy Director of Strategy to the meeting. Linsay Cunningham took the paper as read and provided an overview of key issues and challenges raised through the public HASR consultation. An update on progress towards completing the Decision-Making Business Case (DMBC) was provided which would be presented to the Trust Boards-in-Common for a formal decision. It was noted the consultation had run from 25 September 2023 to 5 January 2024 and received nearly 4,000 responses via the questionnaire with a wide range of views also gathered from seldom heard groups and communities through a comprehensive programme of targeted engagement. Work was ongoing to respond and analyse the public consultation feedback and a detailed report would be provided once available.

Lee Bond referred to the presentation and asked about the potential recommendation to consolidate acute and elective urology services. Linsay Cunningham advised that the rationale was to provide efficiencies, whilst noting acute and elective are in the same place at SGH and the model allows a balance of services.

In response to a query from Lee Bond, Linsay Cunningham confirmed there would be slippage of up to two weeks on the planned review of the Business Case by 1 May 2024 and advised of the close working with the finance team on the figures.

Simon Parkes noted the need to be clear on the recommendation and rationale and queried if there was a clinically sound solution which delivered better value for money, on what basis would another option be taken. Linsay Cunningham advised that the rationale around Urology came from the clinical teams.

Gill Ponder referred to slide 10 and queried the suggestion under emergency surgery, trauma and orthopaedics that the over 65's with fractured neck of femur would be repatriated to SGH for recovery, which may not be patient friendly. Shaun Stacey advised of the importance to keep patients as local as possible with planned repatriation and rehabilitation closer to home.

The Committees were assured about the level of public engagement involved in the review and the progress made to date, and noted the key issues and concerns raised through the consultation, the recommended direction of travel and timeline for the DMBC and next steps.

5.2 Gill Ponder thanked Linsay Cunningham for the update on HASR.

Community Diagnostic Centre (CDC) Programme

Gill Ponder welcomed Jackie Railton, Deputy Director Planning and Performance to the meeting. Jackie Railton took the Committees through an overview of the programme. This included an update on progress of the North and South Bank CDC schemes which were progressing at pace. Scunthorpe and Grimsby were on track to open in October 2024 as planned. In relation to the East Riding Community Hub (CH), the NHSE have challenged the spoke status of this

scheme due to the modalities included, which were agreed by NHSE as part of the original business case, but assumptions have changed. It was noted that the additional modalities/activities would require extra space not currently available at the hub. The planned modular ophthalmology build would not have spare capacity for additional activity and discussions were ongoing with NHSE.

Referring to the East Riding hub, Jackie Railton noted that discussions are underway with the Council regarding the build costs and a potential risk share agreement was in place. The Council and their contractor had submitted revised cost plans and the lack of supporting detail for a potential £3 million cost overrun, which had not been validated by the Estates team, was noted. Discussions were ongoing around the issues with Hull City Council's Section 151 officer to agree a resolution.

Simon Parkes acknowledged that these all need to be in place within 2024 and challenges remain over what will be included in the community hub. He queried who monitored the "value for money" and public accountability elements of the schemes and Jackie Railton advised that value for money would be evident for the Trust once referrals are taken from the GPs into the hub and out of secondary care. This is in line with a value for money assessment which was undertaken as part of the business plan presented to the Trust Board and supported by the Integrated Care Board (ICB) and NHSE. As NHSE had changed the rulings which meant that only one modality could be delivered, some accountability would sit with NHSE.

Jackie Railton referred members to the Grimsby CDC current cost forecast which noted an overrun of approximately £500,000 and advised Estates colleagues were reviewing options to maintain the planned contingency. It was noted that the opening had been delayed from April 2024 to October 2024. The Scunthorpe CDC was progressing at speed with one outstanding issue around the Council ownership of the adjacent sports hall which was required for the location of the mobile pad. This risk was currently being managed between teams.

More care pathways were being identified for the south bank services including breathlessness and heart failure and opportunities around gastroenterology, urology and gynaecology. Demand for point of care testing had been lower than anticipated which may impact activity levels and the revenue position which were under review. Jackie Railton advised that plans were in place for staff recruitment and training with the option to utilise the independent sector for support with Sonographer recruitment.

Planned activity for the computed tomography scan (CT) and Magnetic resonance imaging (MRI) demand was lower than planned; this was due to the need for only "low complex" patients and adjustments are being worked through. As this was a system provision across mobile vans and sites these will be utilised elsewhere and therefore would not impact on the overall position.

Tony Curry queried any difficulties in the recruitment of Sonographers and queried why the service was not outsourced. Jackie Railton advised the work needs to be delivered on site and there were very strict rules that must be adhered to. Gill Ponder asked how realistic the recruitment of all trained staff would be in order to open these facilities on time. Lee Bond confirmed that Ivan

McConnell had reported a high confidence level for recruitment except for radiologists.

Gill Ponder thanked Jackie Railton for the update and Jackie Railton left the meeting.

Review The Committees were assured on both the HASR and CDC Programme.

6. Digital

6.1 Digital Plan Delivery – Bi Monthly Update

Alastair Pickering advised the Committees that since the last update three major projects had been delivered or were in progress. The patient administration system (PAS) migration to a single Lorenzo system had been a significant piece of work that had impacted significantly on the south bank and affected the north bank during the cross-over period. This was a successful technical migration, but there had been a significant number of post implementation challenges in practice. The programme was due to enter a stabilisation stage prior to an optimisation stage, but currently south bank staff are not ready for the system to be optimised at present. A project team was available to support this work and it was noted that some areas are already working extremely well.

An issue with resource availability of the Information Teams on the south bank was noted which had been impacted by the work on the data warehouse.

Successful Implementation of the Badgernet Maternity system across HUTH had been undertaken and a slight training issue had been addressed. As there were three different maternity systems on the south bank, the implementation would undergo a “reset” to address identified issues which included data cleansing, training data reporting and working with the service areas. Alastair Pickering advised that a new Project Management group supported this work and a progress update would be presented to the Trust Boards-in-Common and the Group Cabinet.

Moving on to the Electronic Patient Record (EPR), Alastair Pickering referred to the business case and procurement process and advised that Andy Hayward, Chief Information Officer had requested the Trust Boards-in-Common to support a delay until June/July 2024. It was noted that York, Scarborough and Harrogate are procuring their own EPR system with a decision due in May. Potential cost savings on the Group’s business case were being investigated with the national team.

Tony Curry acknowledged the challenges in informatics and queried any plans for artificial intelligence (AI) and end user tools to address some of the challenges. Then moving to EPR, Tony Curry requested an update on timescales and Alastair Pickering confirmed the current contract was with Lorenzo until 2028 with an option to extend to 2030.

Julie Beilby asked if there was a “shared ambition” for an EPR between York, Scarborough and Harrogate Trusts to move to a single supplier. Alastair Pickering confirmed that there was commitment to a single system procurement.

Simon Parkes queried whether the Information team and other staff challenges had impacted progress on normal management reporting and whether there was a robust process for prioritising such elements. Alastair Pickering confirmed that the Information team as part of the PAS project did prioritise effectively, but had found it difficult to keep abreast of the pace of the implementation.

Simon Parkes expressed concern around the inability to receive assurance on the data gaps and Shaun Stacey confirmed there were daily challenges which were managed as well as possible. Sufficient operational quality controls were utilised in patient services to mitigate 'losing someone' on the pathway.

Gill Ponder suggested the Committees sought additional assurance on the lack of timely and appropriate reporting functionality following the data migration to Lorenzo. A report was requested to be presented to the May 2024 Performance, Estates and Finance (PEF) CiC meeting to note where the gaps were and the mitigations and timescales identified to address them. It had been noted that the patient safety risk had been mitigated by the operational teams, but this required several manual work-arounds. Shaun Stacey noted that additional staff had supported the LORENZO roll-out on the south bank to address some critical challenges, although the technical migration and training went very well and lessons had been learned. Shaun Stacey referred to the importance of keeping the Trust Boards-in-Common sighted on this.

ACTION - Ivan McConnell to present a report to the May 2024 Performance, *Estates and Finance (PEF) CiC meeting to provide assurance on timely and* accurate reporting following the migration of data to Lorenzo, including where any data gaps were and the mitigations and timescales identified to address them.

Review The Committees gained assurance from the digital plan delivery update and would highlight the 'go live' date for the NLaG Badgernet was being re-planned to the Trust Boards-in-Common. Concerns regarding the level of resource within the digital team were to be escalated. The data and reporting gaps identified were also to be escalated following the Lorenzo data migration which were leading to manual workarounds, although any patient safety risk was mitigated by the operational teams, the Committees sought assurance of where the gaps were and the timescales for resolution (referred to the May PEF CiC).

7. Highlight Reports from Sub-Groups

7.1 Capital Resource Allocation Committee Minutes February 2024 - HUTH

The minutes taken at the Capital Allocation Committee in February 2024 were noted.

7.2 Capital Investment Board Minutes February 2024 - NLaG

The minutes taken at the Capital Investment Board in February 2024 were noted.

Referring to items 7.1 and 7.2, Lee Bond advised that he was producing a draft ToR for a new Group Cabinet Capital Committee which would be presented to Group Cabinet, this would be an amalgamation of the two Capital meetings. Once approved the ToR would be presented to this Committee.

8. ANY OTHER URGENT BUSINESS

There were no items of any other business raised.

9. MATTERS TO BE REFERRED BY THE COMMITTEES

9.1 Matters to be Referred to other Board Committees

It was agreed to refer the following matters to other Board Committees as noted:

- Audit, Risk and Governance – Risk Register
- Performance, Estates and Finance – Data reporting gaps following Lorenzo implementation

9.2 Matters for Escalation to the Trust Boards

In addition to the items highlighted above at each agenda section review for inclusion in the Committees' highlight report, it was agreed that the following matters required approval by the Trust Board(s):

- Approved Terms of Reference
- Endorsed Draft Capital Programme
- Endorsed North East Lincs CDC

10. Items for Information

10.1 Complete Board Assurance Framework (BAF) – for Reference (HUTH & NLaG)

David Sharif took the paper as read and noted that work was underway to refresh the BAF across the Group. The report included a progress update regarding the harmonisation and rationalisation of the BAFs for HUTH and NLAG together with the 2023/24 Quarter 4 Digital risk rating, the re-scoped 2024/25 Group Digital risks and updated controls, assurances and gaps in controls. The Committees were asked to note the report.

Tony Curry queried the assurance rating on the IT failure and queried how robust the facilities at NLaG were which was not reflected in the rating. Alastair Pickering confirmed that the rating of 15 was the initial proposed rating but was open for discussion. Gill Ponder suggested it be presented to the Risk Management Committee and the CaMP CiC would receive the BAF in its further iteration with the risk score following debate and justification.

11. DATE AND TIME OF THE NEXT MEETING

11.1 Date and Time of the next CiC meeting:

Tuesday, 25 June 2024, 9.00am, Boardroom, Hull Royal Infirmary.

The Committee Chair closed the meeting at 12.00 noon.

Cumulative Record of Attendance at the Capital & Major Projects Committees-in-Common 2024/2025

		2024				
Name	**Title**	**Apr**	**Jun**	**Aug**	**Oct**	**Dec**
CORE MEMBERS						
Gill Ponder	Chair / Non-Executive Director (NED - NLaG)	Y				
Mike Robson	Chair / NED (HUTH)	Y				
Lee Bond	Group Chief Financial Officer	Y				
Tony Curry	NED (HUTH)	Y				
Simon Parkes	NED (NLaG)	Y				
Shaun Stacey	Group Chief Delivery Officer	Y				
Quoracy: *three of five core members (inc.one of two Trust NEDs, two Group Executive Directors or appointed deputies)*						
REQUIRED ATTENDEES						
VACANT	Group Director of Estates	D				
VACANT	Group Director of Transformation	V				
Andy Hayward	Group Chief Digital Information Officer	D				
Alison Drury	Deputy Director of Finance (HUTH)	Y				
Ivan McConnell	Group Chief of Strategy & Partnerships	Y				
Ian Reekie	Governor Observer (NLaG)	Y				
David Sharif	Group Director of Assurance or deputy	Y				

DESIGNATED DEPUTIES	
Executive Director CiC member	**Designated Deputies**
Lee Bond Group Chief Financial Officer	Deputy Chief Financial Officer – vacant, covered by: Alison Drury, Deputy Director of Finance (HUTH) Brian Shipley, Deputy Director of Finance (NLaG) Steve Evans, Operational Director of Finance (HUTH)
David Sharif Group Director of Assurance	Alison Hurley, (NLaG) Rebecca Thompson, Deputy Director of Assurance (HUTH)
Ivan McConnell Group Chief of Strategy & Partnership	Adam Creeggan, Group Director of Performance
Shaun Stacey Group Chief Delivery Officer	Ashy Shanker – Managing Director - South Bank Neil Rogers – Managing Director - North Bank

***KEY**: **Y** = attended **N** = did not attend **D** = nominated deputy attended **V** = position vacant*

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)165

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	8 August 2024
Director Lead	Ivan McConnell, Group Chief Strategy & Partnerships Officer
Contact Officer/Author	Adam Creegan, Group Director of Performance
Title of the Report	Integrated Performance Report
Executive Summary	This report provides details of performance achieved against key national performance, quality and governance indicators defined in the NHSE Single Oversight Framework (SOF)
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	Presented to the Performance, Estates and Finance Committees-in-Common, Workforce, Education & Culture Committees-in-Common and Quality & Safety Committees-in-Common July 2024
Financial implication(s) (if applicable)	The report covers a number of metrics that relate to financial performance inclusive of Elective Recovery Fund activity versus published plan
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below: The Trust Board are asked to note the report

NHS
Humber Health
Partnership

Integrated Performance Report

MONTH 3: June 2024 Performance

May 2024 for Cancer data
Produced July 2024

Table of Contents

1. Executive Summary

This report provides an overview of the Group's performance across a range of metrics with specific detail in relation to each individual Trust.

Domain	HUTH Performance	NLAG Performance	Commentary
ED: 4 hour standard (Type 1 & 3) 78% by March 2025	**61.0%** **Trust compliance** **69.4% (plan 74.1%) Acute Footprint compliance (incl. Bransholme & ERCH)**	**69.2%** **Trust compliance** **81% (plan 72.3%) Acute Footprint compliance (incl. Goole UTC)**	• Type 1 and 3 performance has remained static month on month at HUTH. National compliance ranking has remained broadly unchanged at 133 of 142 providers reporting in June. • NLaG compliance was also broadly unchanged on the previous month and benchmarks in the interquartile range of national ranking at 98 of 142. • Both Group Trusts exceeded Acute Footprint delivery targets however aggregate compliance versus plan was constrained by delivery at Bransholme (83.5%) and East Riding Community Hospital (84.4%) versus expectation of >95%. • Both short-and medium-term recovery plans co-produced at Place level. Final assurance and acceptance of plans underway at system level – improvement trajectories will be published on completion. • 6 week reset patient flow campaign planned in August to engage and motivate staff across the pathway, and improve quality and patient experience.
RTT Long Waits • 104 weeks • 78 weeks • 65 weeks • 52 weeks	 **0** **0** **20** **1,913**	 **0** **0** **61** **719**	• Achieved the national requirement for zero >78w waits at end of June. • Continued progress in reducing >65w volumes at HUTH. • Increase in number of >65w waits at NLAG, predominantly due to Community Dentistry capacity • On track to achieve zero >65w waits at end of September.
Diagnostic 6w Performance	**23.4%**	**12.0%**	• Both HUTH and NLaG benchmark positively with NLAG being close to the lower quartile nationally (low being better). Both Trusts have shown significant improvements since September 2023; HUTH has improved from 40% to 23.4% and NLAG has improved from 37% to 12.0%. • There is significant variation in compliance at modality level across Trusts, driving a need to equalise waits within the Group and modalities have developed action plans to address this.
Cancer 62 day Performance	**May 2024** **62.8%**	**May 2024** **47.1%**	• Both Trusts in formal Tier 1 for Cancer delivery and are working with NE&Y Regional Office on recovery through that assurance process. • Tumour Site 28 days Faster Diagnosis Standard (FDS) sustainability plans developed and being implemented via the Cancer Delivery Group Operational planning target to achieve FDS (combined) performance of 80% by March 2025 at Trust level • +63 day backlog reviews implemented fortnightly across the group

2. Pathway Summary – Benchmark Report – Elective Care

NB: National benchmarking data is a month in arrears due the NHSE publication timetable

HUTH

Indicator	Period	Target		SPC	Last 12 Months	Centile
RTT 52 Week Breach	May 24	0	1,971			37
RTT 65 Week Breach	May 24	-	27			70
RTT 78 Week Breach	May 24	0	7			37
RTT 95th Percentile Admitted Waiting Time	May 24	18.0	62.1			59
RTT 95th Percentile Non-Admitted Waiting Time	May 24	18.0	52.1			52
RTT Admitted Treatment Within 18 Weeks	May 24	90.0%	56.0%			51
RTT Average (Median) Admitted Waiting Time	May 24	9.0	13.7			54
RTT Average (Median) Non-Admitted Waiting Time	May 24	5.0	7.4			78
RTT Average Wait for Incomplete	May 24	7.00	14.0			49
RTT Incomplete 18 Week Standard	May 24	92.00%	59.7%			49
RTT Incomplete 92nd Percentile	May 24	-	43.1			52
RTT Incomplete Pathways With a DTA	May 24	25.0%	17.0%			39
RTT Non-Admitted Treatment Within 18 Weeks	May 24	95.0%	71.4%			67
RTT Total Clock Starts	May 24	-	19,759			90
RTT Total Clock Stops	May 24	-	18,031			92
RTT Total Incompletes	May 24	-	76,421			17

NLAG

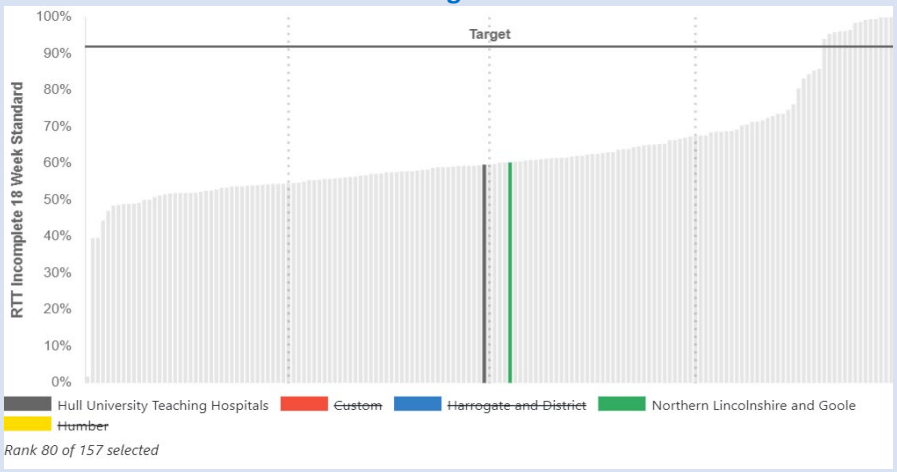
Indicator	Period	Target		SPC	Last 12 Months	Centile
RTT 52 Week Breach	May 24	0	696			60
RTT 65 Week Breach	May 24	-	53			61
RTT 78 Week Breach	May 24	0	5			42
RTT 95th Percentile Admitted Waiting Time	May 24	18.0	58.8			72
RTT 95th Percentile Non-Admitted Waiting Time	May 24	18.0	50.7			58
RTT Admitted Treatment Within 18 Weeks	May 24	90.0%	58.4%			60
RTT Average (Median) Admitted Waiting Time	May 24	9.0	12.9			61
RTT Average (Median) Non-Admitted Waiting Time	May 24	5.0	11.3			30
RTT Average Wait for Incomplete	May 24	7.00	14.1			48
RTT Incomplete 18 Week Standard	May 24	92.00%	60.3%			52
RTT Incomplete 92nd Percentile	May 24	-	40.0			70
RTT Incomplete Pathways With a DTA	May 24	25.0%	13.1%			59
RTT Non-Admitted Treatment Within 18 Weeks	May 24	95.0%	63.8%			38
RTT Total Clock Starts	May 24	-	9,963			54
RTT Total Clock Stops	May 24	-	8,826			56
RTT Total Incompletes	May 24	-	46,391			41

3. Pathway Benchmarking & Trend – Elective Care

NB: National benchmarking data is a month in arrears due the NHSE publication timetable

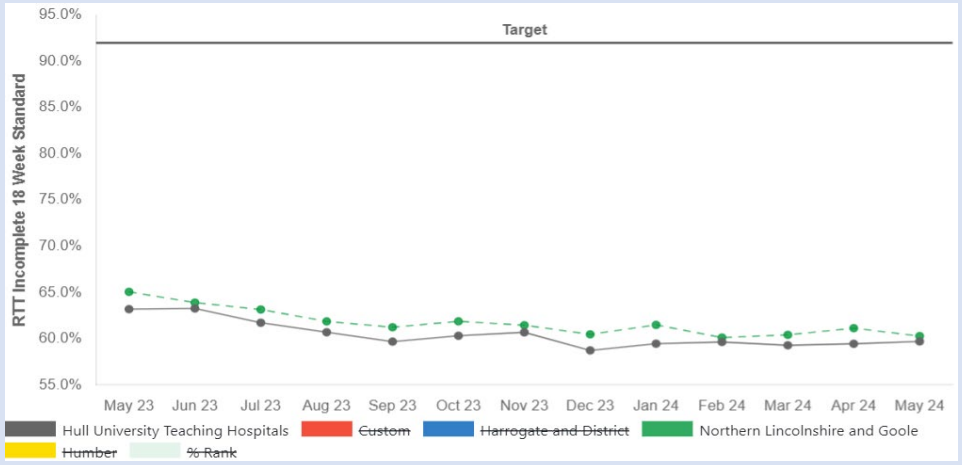
RTT – Incomplete Standard

Ranking Chart



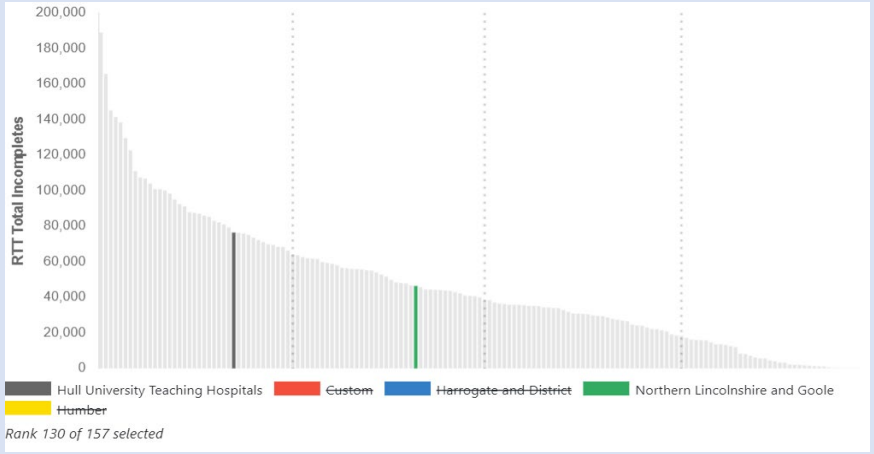
Rank 80 of 157 selected

Trend Chart



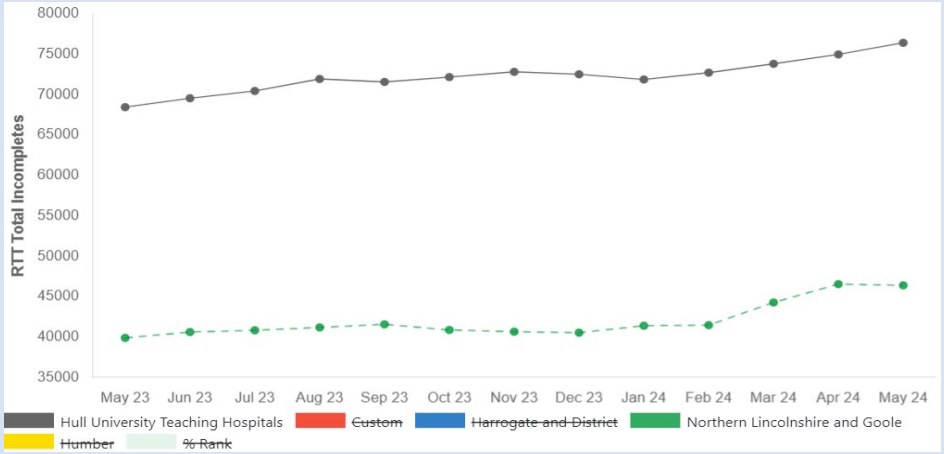
RTT – Total Waiting List Volume

Ranking Chart



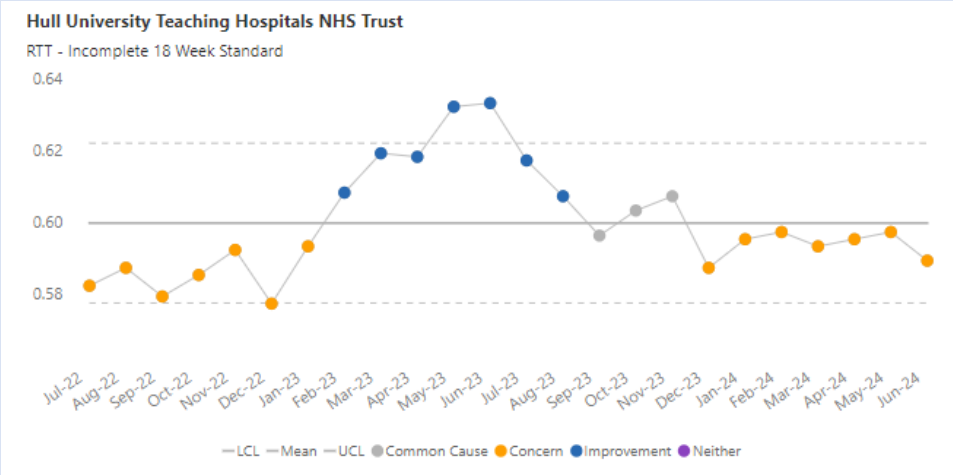
Rank 130 of 157 selected

Trend Chart



3. Referral to Treatment - HUTH

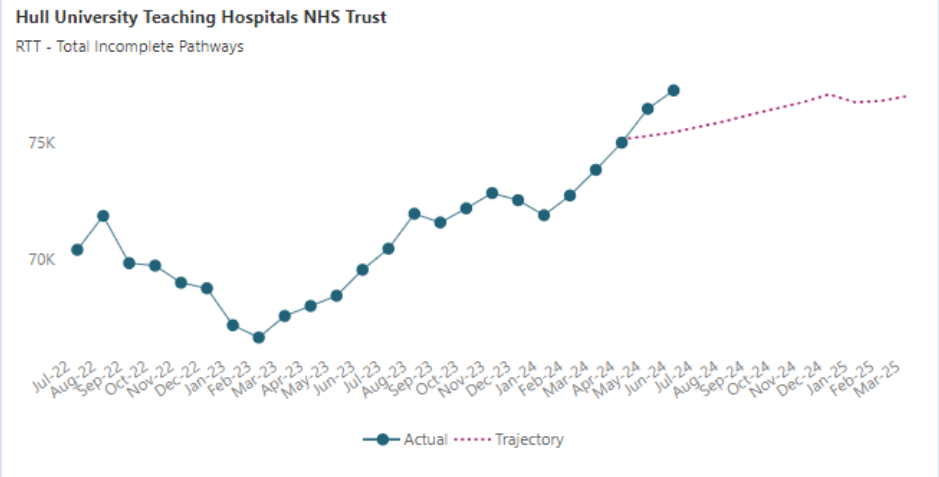
Compliance



Key Themes

- June performance of 58.9% which is broadly similar to previous months.
- Currently 58.0% of patients on the PTL are awaiting a first outpatient appointment. Largest volumes in ENT, Ophthalmology, Dermatology, Cardiology and Neurology
- Average wait for incomplete pathway is 14 weeks against a standard of 7 and is currently rising.
- Increasing waiting list volume underpinned by 5.7% growth in referral rate.
- June total waiting list volume is above the trajectory (+1,786)

Critical Enabler



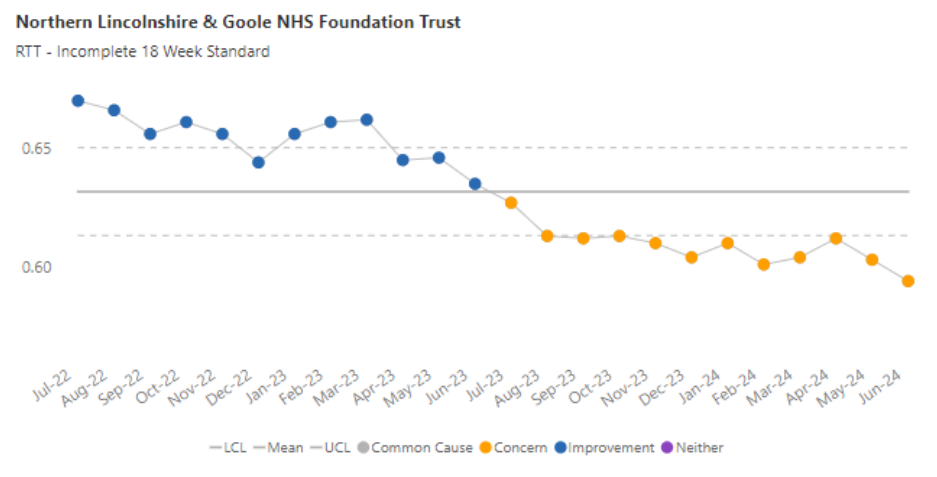
Actions

Critical actions being progressed through RTT Delivery Group:

- Waiting list volume is the key focus to bring back under trajectory
- Ensure all patients who will be at 65 weeks by the end of December have a first seen appointment by end of September 2024.
- Increase first outpatient activity to restore 19/20 baseline. Where 19/20 baseline is being achieved Care Groups have identified additional activity schemes over and above the 24/25 operational plan to achieve additional Elective Recovery Funds income
- Care Groups reviews to decrease waits for first outpatient activity >13 weeks.
- Reallocate follow up outpatient activity without a procedure.
- Remedial admin action plans deployed to resolve pathway outcome recording delays to reduce total waiting list volume.

4. Referral to Treatment - NLAG

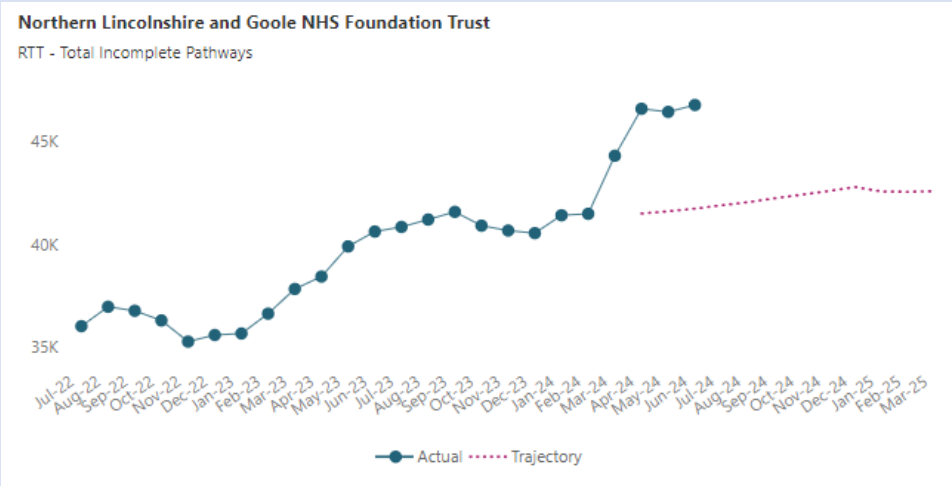
Compliance



Key Themes

- June performance of 58.4% was a 1% improvement on the previous month. This is set against a broadly static trend for the last 11 months and reflects the mathematic impact of PTL growth.
- RTT waiting list volume is above trajectory at 46,730 (+5,017).
- Data recording and validation backlogs post Lorenzo have driven increase in Patient Tracking List (PTL) from February.
- This is a predicted post deployment impact and resource have been enacted to transact all outstanding pathway events – this action stabilised PTL growth from May.
- Detailed review of all outstanding pathway events requiring admin transaction is ongoing.

Critical Enabler



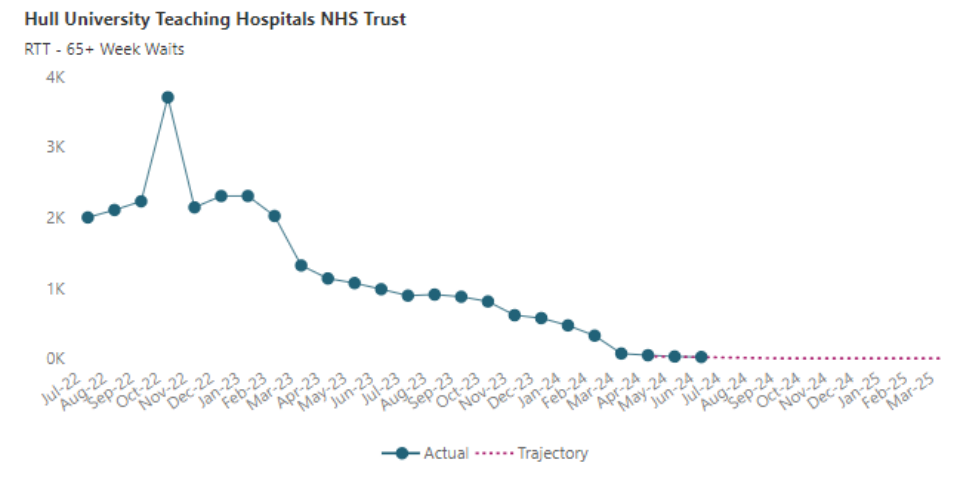
Actions

Critical actions being progressed through RTT Delivery Group

- Waiting list volume is the key focus to bring back under trajectory
- Increase first outpatient activity and decreased waits for first outpatient activity >13 weeks.
- Decrease follow up outpatient activity without a procedure.
- Care Groups to identify additional activity over and above the 24/25 operational plan to achieve additional Elective Recovery Funds
- Remedial action plans deployed to resolve pathway outcome recording delays to reduce total waiting list volume which have stabilised growth. Recruitment to 10 x validators underway and interim admin resourcing sourced via HUTH RTT team, medical records, etc.
- RTT Insights Model being deployed to NLAG which will greatly assist operational teams in management oversight and scrutiny of their PTL – currently undergoing User Acceptance Testing

5. Referral to Treatment – 65w Waits - HUTH

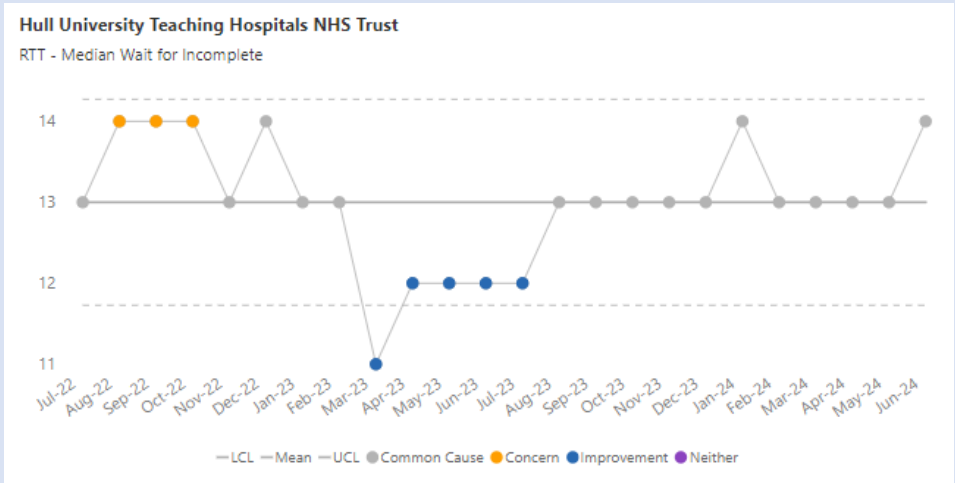
Compliance



Key Themes

- On plan to deliver elimination of 65 week waits by Sept ’24.
- 20 patients exceeding 65 weeks reported at the end of June against a plan of 18.
- Forecast position for end of July of 15
- Challenged areas
    - Plastic surgery complex hand
    - Patient choice

Critical Enabler



Actions

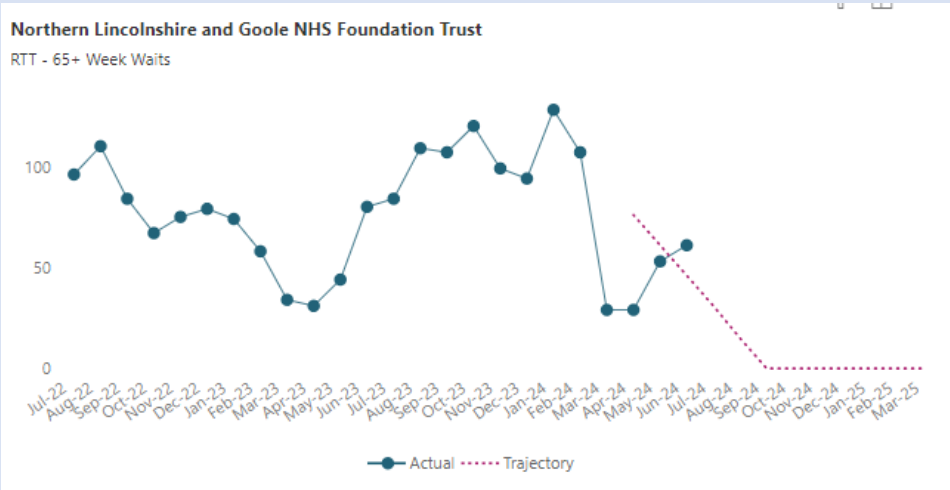
1. Elimination of >78w waits by end of June 2024 - delivered
2. Elimination >65w waits by end of September 2024
3. Reduce >52w waits by end of March 2025

Critical actions being delivered through the RTT Delivery Group

- Ensure all patients who will be a >65w risk for end of December have a first appointment by end of September 2024
- Continued focus at speciality level of patients dated and/or risks now focussed to eliminate the number of >65-week waits by the end of September 2024
- Delivery of 24/25 operating plan activity extension plans.
- Additional weekend waiting list initiatives to create capacity in Plastic surgery

6. Referral to Treatment – 65w Waits - NLAG

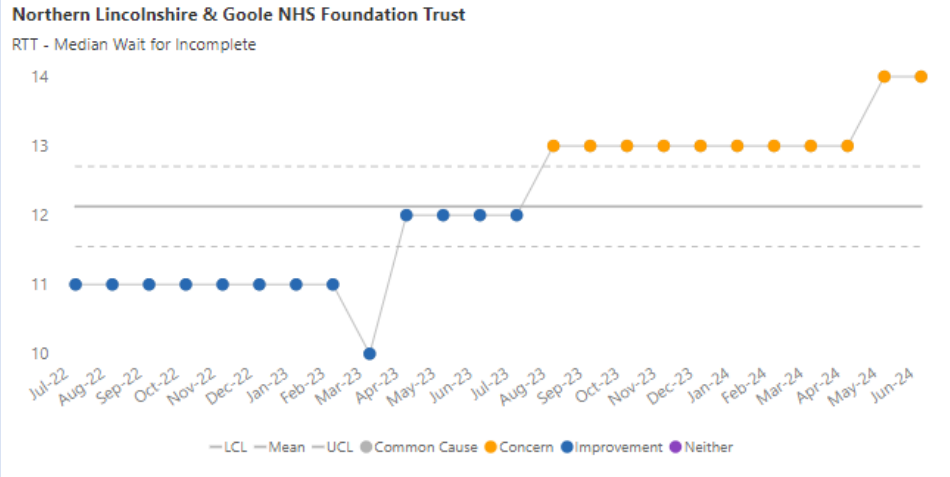
Compliance



Key Themes

- Deterioration in 65w waits at the end of June with 61 breaches – main issues:-
  - 42 x Community Dentistry due to capacity constraints in paediatric pre-op and theatres at Scunthorpe
  - 7 x Gynaecology
  - 4 x T&O
  - 9 x Other
- Deterioration in median waits from 10 weeks to 14 weeks (national standard 7 weeks) since March 2022 – noting this will reflect the admin backlog currently inflating the PTL
- Forecast for end of July is currently 31 with main concern in Community Dentistry and ENT

Critical Enabler



Actions

1. Clear >78w waits by end of June 2024
2. Clear >65w waits by end of September 2024
3. Reduce >52w waits by end of March 2025

Critical actions being delivered through the RTT Delivery Group

- Ensure all patients who will be a >65w risk for end of December have a first appointment by end of September 2024
- Delivery of 24/25 operating plan activity extension plans.
- Ensure patients that will breach >65w by end of September to have a first seen appointment by end of June
- Review of weekly meeting structure to provide increased oversight and scrutiny
- Additional weekend capacity throughout July and August in Community Dentistry to reduce the number of long waits
- Paediatric – ADHD pathway >65 week breach risk mitigations

7. Referral to Treatment – Data Quality - HUTH

Compliance

79,396	3,633	3,730	99.42%	4.58%
Pathways on RTT PTL	Pathways with Metrics	DQ Metrics on RTT PTL	RTT PTL Confidence Level	% Pathways with Metrics on RTT PTL

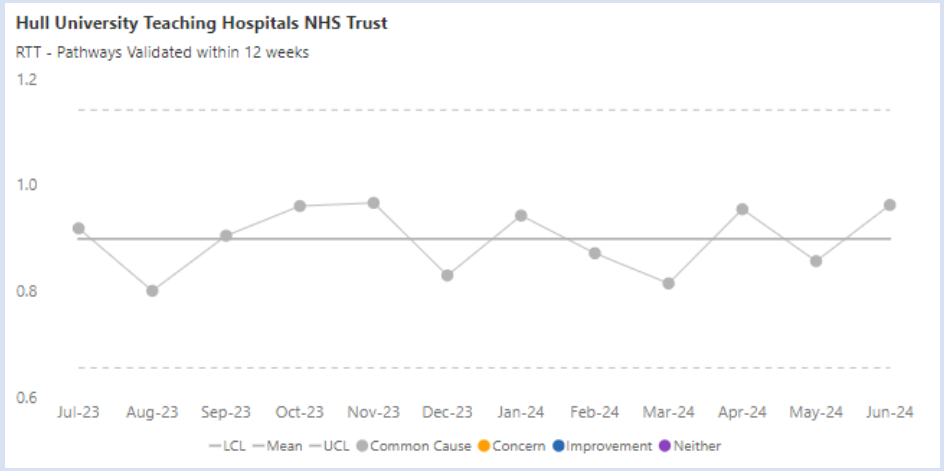
Key Themes

It is an NHSE mandated reporting requirement for Board to receive oversight of RTT Data Quality.

The Trust has robust oversight arrangements in place to support timely validation, these are monitored by RTT BI data quality reports in conjunction with the LUNA system, with established escalation processes in place. LUNA is currently reporting that the Trust has a 99.42% confidence level for RTT PTL data quality.

For those pathways validated every 12 weeks there has been an increase to 96.2% which remains significant ahead of the national 90% standard.

Critical Enabler



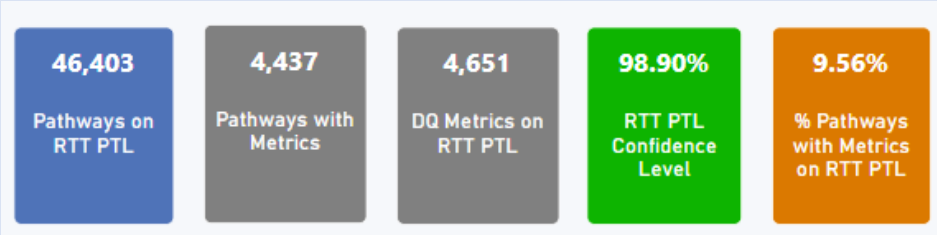
Actions

Critical actions to be taken:

- Business as usual process in place between the Performance and CAS teams
- BI data quality reports are used to monitor weekly and escalation processes are in place.
- Focus by CAS on ensuring the pathways over 12 weeks have an up-to-date validation comment

8. Referral to Treatment – Data Quality - NLAG

Compliance

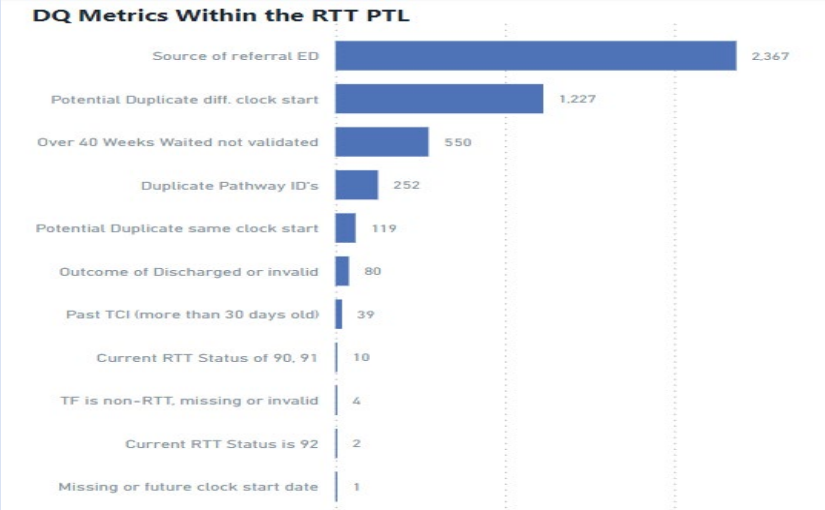


Key Themes

It is an NHSE mandated reporting requirement for Board to receive oversight of RTT Data Quality.

- LUNA data quality is showing a 98.9% confidence rate and there has been an improvement in the % of pathways with metrics due to a reporting adjustment. Improved from 26.16% to 9.56%
- The predominant sub metric generating the DQ flag is pathways validated every 12 weeks the latest data shows 15.9% compliance against the 90% standard
- This links to the admin delay in transacting pathway events post Lorenzo deployment as outlined in the RTT section of this report.

Critical Enabler

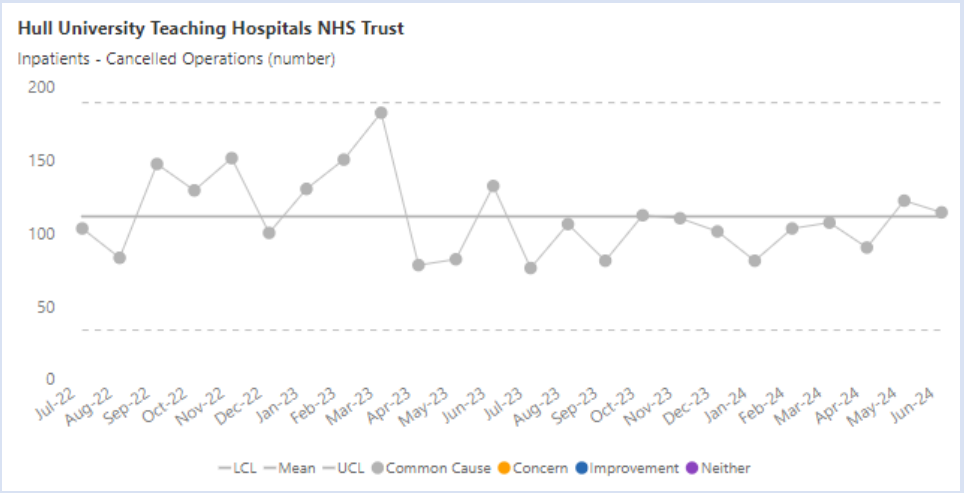


Actions

- Patient Services to reinstate text validation to patients every 12 weeks to confirm patients are still requiring appointments by end of July
- Patient Services to reduce the number of unvalidated pathways and other key DQ reports including un-outcomed clinic and admission attendances to proactivity improve incomplete pathway management.
- 10 additional staff being recruited to support NLAG validation work.
- Focus on improving up-to-date validation / tracking comments to
- Actions identified and deployed in Waiting List Minimum Data Set to re-map the Status 99 (Start date unknown) from June 2024 - completed

9. Cancelled Operations - HUTH

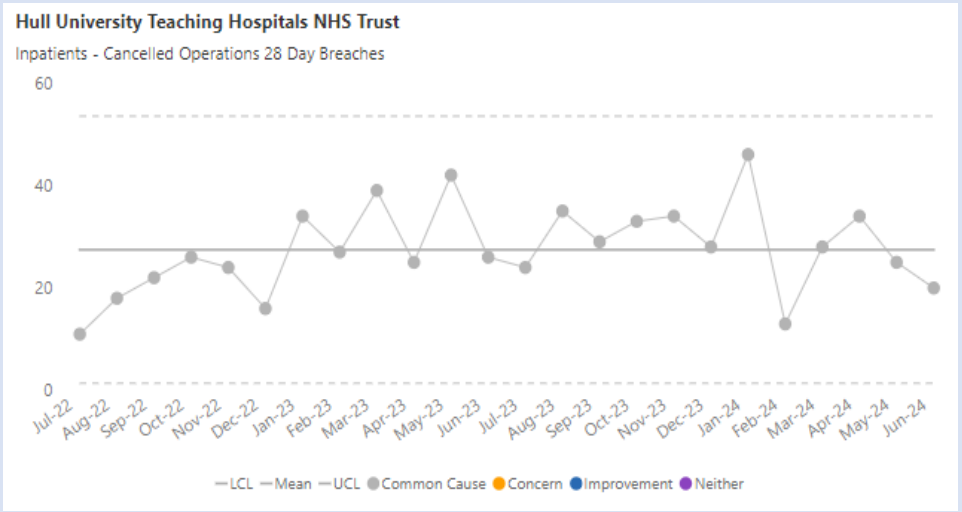
Compliance



Key Themes

- HUTH sits at 1.4% of operations cancelled on the day for non-clinical reasons against a performance tolerance of 0.65%.
- In June there were 114 cancelled operations on the day for non-clinical reasons.
- Most of these reasons are recorded as “no bed” or “theatre list over-ran”
    - 23 x Gynaecology (18 no theatre time)
    - 23 x Interventional Radiology (15 no beds)
    - 12 x Vascular surgery (7 no beds, 4 no theatre time)
    - 10 x Urology (5 no beds, 3 no theatre time)
- There were 20 patients not rebooked within 28 days of their cancellation which equates to 17.5% (target of <5%).

Critical Enabler

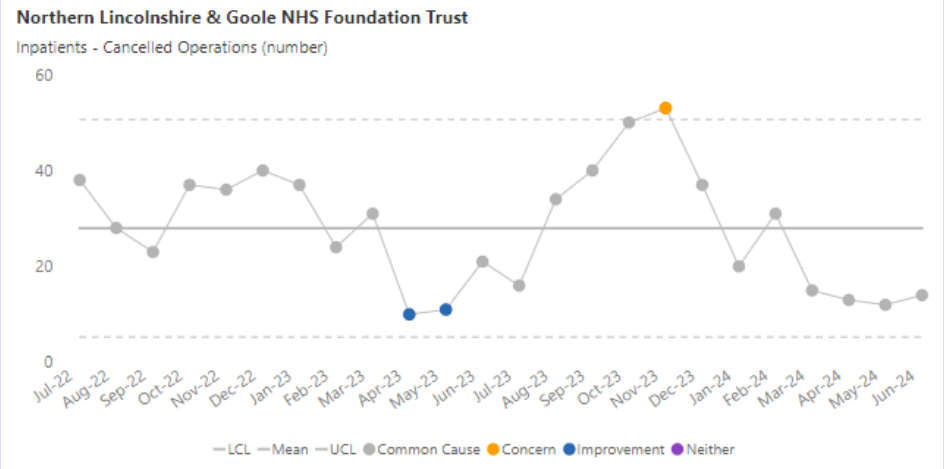


Actions

- Group level Cancelled operations Standard Operating Procedure (SOP) developed and deployed with the Operations Director for Theatres responsible for approving all on the day cancellations
- Robust cancelled operations performance monitoring systems deployed at Group level including 28 day re-bookings reviewed weekly by Site Managing Director
- Review of cancellations trends and themes escalated to the speciality / pre-assessment teams.
- Focus at operational meetings regarding beds required for elective procedures to take place with review of 7/5/2 day pre-op to commence in Orthopaedics and ENT.
- 85% Capped utilisation report and actions going out to all Care Groups from 17th June.
- Progress GIRFT actions for High Volume Low Complexity activity.

10. Cancelled Operations - NLAG

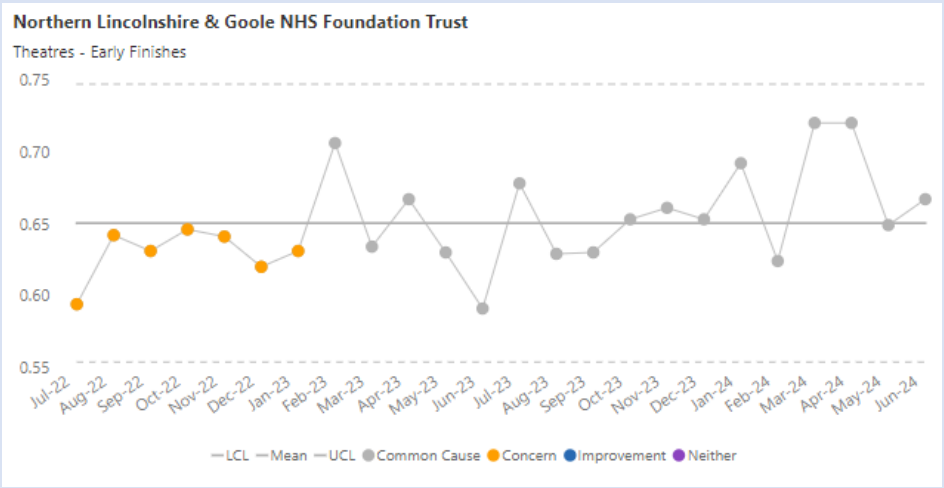
Compliance



Key Themes

- NLAG sits at 0.7% - just above the 0.65% standard.
- In June there were 14 elective cancellations on the day for non-clinical reasons
  - 9 due to theatre list over-runs
  - 4 cancelled on day (no reason)
  - 1 instrument/pack problems
- 100% of theatre sessions in June had late starts based on recorded session start time.
- 67% of theatre sessions in June finished early

Critical Enabler

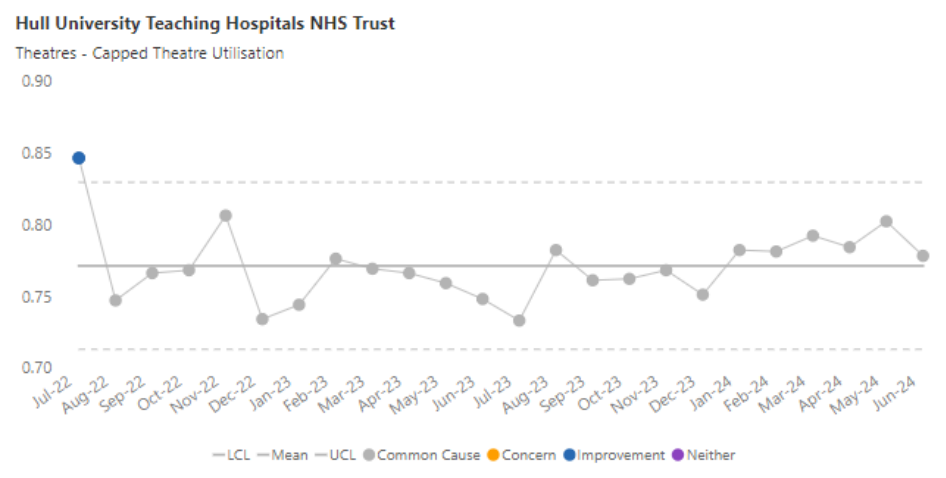


Actions

- Enhanced BIU support to report national data set and eliminate DQ issues.
- Additional daily scrutiny and feed back to specialities regarding capped utilisation and the additional minor patient to be added to all lists not delivering 85% utilisation.
- HUB commenced at GDH 10th June 2024, to support LoS and GIRFT standards improvement.
- Working with NHSE/GIRFT on improvement recommendations
- Reviewing all opportunities to sweat current assets.
- Cancelled operations Standard Operating Procedure (SOP) has been reissued at Group level with the Operations Director for Theatres responsible for approving on the day cancellations
- Standing down or lifting sessions SOP completed and deployed.

11. Capped Theatre Utilisation - HUTH

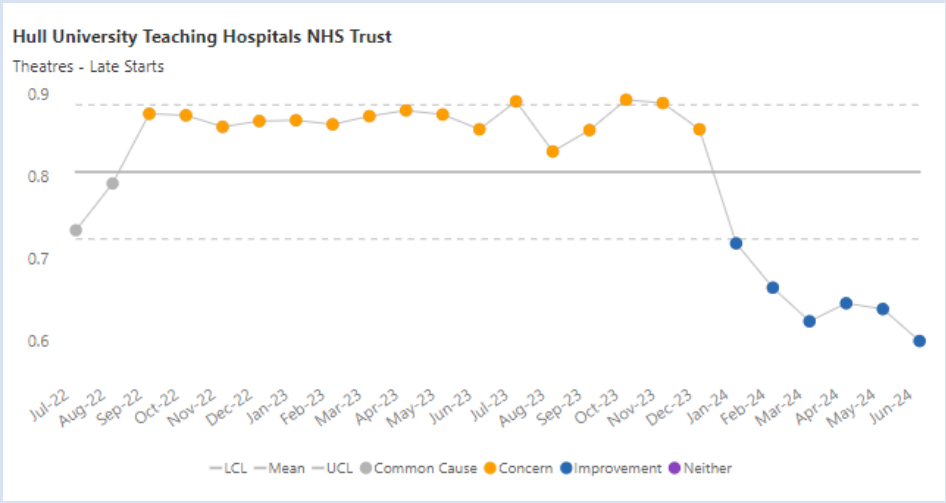
Compliance



Key Themes

- Slight deterioration in capped theatre utilisation with latest Model Hospital data showing performance at 80.8% placing the Trust in the third highest quartile nationally.
- Internal reporting at 78.0% for capped theatre utilisation, however, methodology has been updated in July which will more closely match the Model Health calculation.
- Day Case capped theatre utilisation is trending at 76% - improving this element of delivery is the critical enabler to improve to the aggregate activity standard of 85%.
- HUTH specifically commended on delivery of capped utilisation improvement by Professor Tim Briggs, Chair of GIRFT and NHSE National Director for Clinical Improvement & Elective Recovery.
- Improvement in late starts (methodology 0 minutes = late start)

Critical Enabler

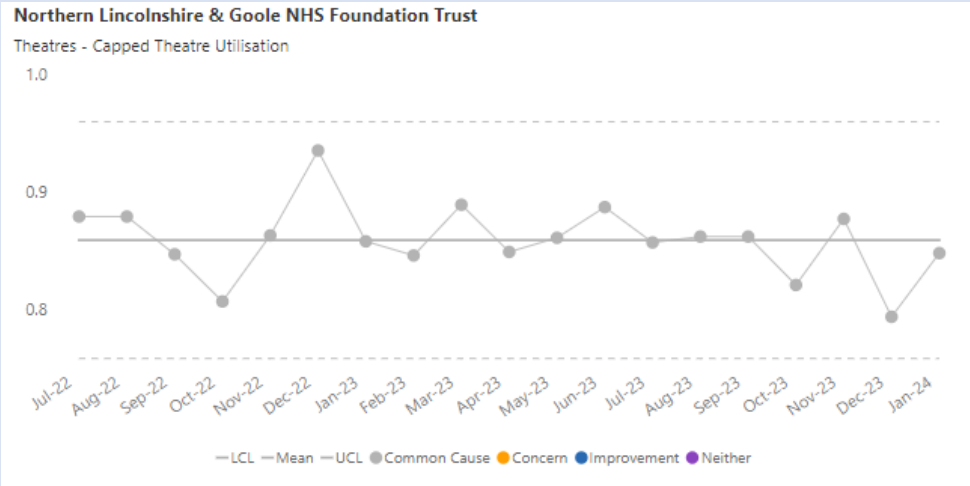


Actions

- Theatre Data Quality dashboard in place which is managed daily by the Theatres, Anaesthetics and Critical Care Group
- Theatres Insights Model being implemented – testing underway by the Information Team.
- Roll out of the model commenced in June and will proved the essential intelligence required to target theatres needing to improve recording of data and achieve the 85% standard
- Improve recording of day case touch points in ORMIS
- Implementation in June of 1 extra patient per day case list for any list at <85% capped utilisation

12. Capped Theatre Utilisation - NLAG

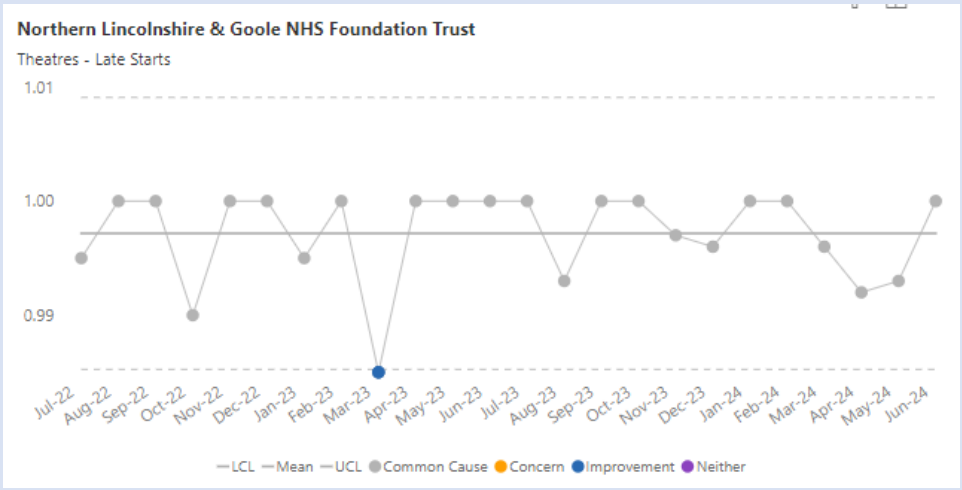
Compliance



Key Themes

- In the lower quartile nationally at 73.9% on Model Hospital, however, internal reporting shows improvement at 84.8%.
- This reflects ongoing issues with data alignment to Model Hospital methodologies, with delay in rectification linked to redirection of all available analytical resource to activity reporting for income generation post Insource data warehouse deployment.
- Day Case capped theatre utilisation is trending at 77% - improving this element of delivery is the critical enabler to improve beyond the 85% standard.
- Theatre late starts issue at NLAG with 100% of sessions starting late in June 2024. Change in timing of the team brief commenced from 1st July 2024 which should significantly improve compliance of on-time starts.

Critical Enabler



Actions

- CAP working group established with Theatre and Analytical leads to apply learning from HUTH analysts on improvement work undertaken on data quality issues with the fortnightly submissions to Model Health and the methodologies applied.
- BI reporting being reviewed due to issues with how the theatre sessions are recorded on WebV, currently sessions are not differentiated between day case and elective theatres, which creates significant issues based on Model Hospital calculation methodologies.
- Implementation in June of 1 extra patient per day case list for any list at <85% capped utilisation

13. Pathway Summary – Benchmark Report – Diagnostics

NB: National benchmarking data is a month in arrears due the NHSE publication timetable

HUTH

Indicator	Period	Target		SPC	Last 12 Months	Centile
Audiology	May 24	5.00%	2.1%			82
Barium Enema	May 24	5.00%	0.0%			100
Colonoscopy	May 24	5.00%	**40.8%**			13
Computed Tomography	May 24	5.00%	**9.9%**			28
Cystoscopy	May 24	5.00%	**31.7%**			32
DEXA Scan	May 24	5.00%	**75.3%**			0
DM01 Waiting <13 Weeks	May 24	100.00%	**92.0%**			26
Diagnostic activity levels - Audiology Assessments	May 24	-	524			57
Diagnostic activity levels - Barium Enema	May 24	-	54			85
Diagnostic activity levels - CT	May 24	-	6,314			71
Diagnostic activity levels - Colonoscopy	May 24	-	292			41
Diagnostic activity levels - Cystoscopy	May 24	-	441			91
Diagnostic activity levels - Dexa Scan	May 24	-	399			70
Diagnostic activity levels - Echocardiography	May 24	-	607			34
Diagnostic activity levels - Endoscopy	May 24	-	1,371			67
Diagnostic activity levels - Flexi Sigmoidoscopy	May 24	-	142			75
Diagnostic activity levels - Gastroscopy	May 24	-	496			69
Diagnostic activity levels - Imaging	May 24	-	14,255			64
Diagnostic activity levels - Non Obstetric Ultrasound	May 24	-	4,647			60
Diagnostic activity levels - Total	May 24	-	17,267			63
Diagnostic activity levels - Urodynamics	May 24	-	67			82
Diagnostics - 6 Week Standard	May 24	5.00%	**23.6%**			36
Diagnostics - 6 Week Standard Reversed	May 24	95.00%	**76.4%**			36
Echocardiography	May 24	5.00%	**25.9%**			34
Electrophysiology	May 24	5.00%	-			-
Gastroscopy	May 24	5.00%	**37.2%**			17
Magnetic Resonance Imaging	May 24	5.00%	1.6%			74
Neurophysiology	May 24	5.00%	**21.4%**			38
Non-obstetric Ultrasound	May 24	5.00%	**8.9%**			39
Urodynamics	May 24	5.00%	**74.5%**			13

NLAG

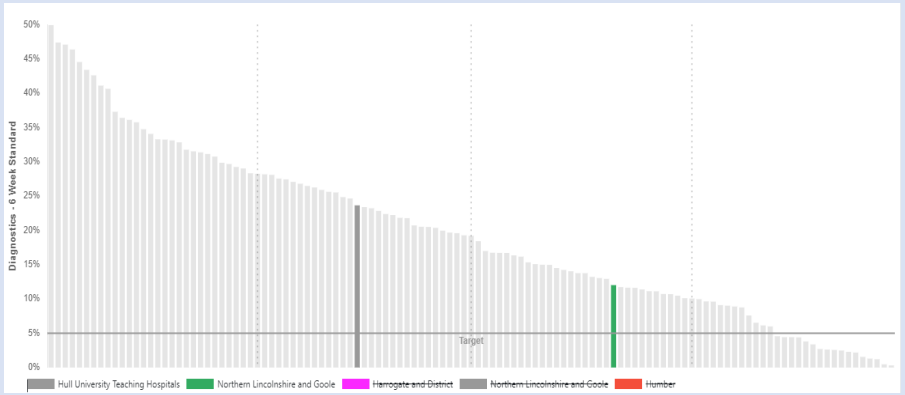
Indicator	Period	Target		SPC	Last 12 Months	Centile
Audiology	May 24	5.00%	**42.8%**			28
Barium Enema	May 24	5.00%	0.0%			100
Colonoscopy	May 24	5.00%	**8.8%**			52
Computed Tomography	May 24	5.00%	3.7%			45
Cystoscopy	May 24	5.00%	**14.1%**			56
DEXA Scan	May 24	5.00%	3.1%			40
DM01 Waiting <13 Weeks	May 24	100.00%	**98.1%**			57
Diagnostic activity levels - Audiology Assessments	May 24	-	489			54
Diagnostic activity levels - Barium Enema	May 24	-	125			96
Diagnostic activity levels - CT	May 24	-	11,233			96
Diagnostic activity levels - Colonoscopy	May 24	-	683			92
Diagnostic activity levels - Cystoscopy	May 24	-	612			99
Diagnostic activity levels - Dexa Scan	May 24	-	243			44
Diagnostic activity levels - Echocardiography	May 24	-	1,025			56
Diagnostic activity levels - Endoscopy	May 24	-	2,463			97
Diagnostic activity levels - Flexi Sigmoidoscopy	May 24	-	298			97
Diagnostic activity levels - Gastroscopy	May 24	-	870			93
Diagnostic activity levels - Imaging	May 24	-	20,926			89
Diagnostic activity levels - Non Obstetric Ultrasound	May 24	-	4,350			54
Diagnostic activity levels - Total	May 24	-	25,299			90
Diagnostic activity levels - Urodynamics	May 24	-	149			94
Diagnostics - 6 Week Standard	May 24	5.00%	**12.0%**			64
Diagnostics - 6 Week Standard Reversed	May 24	95.00%	**88.0%**			64
Echocardiography	May 24	5.00%	**20.3%**			45
Gastroscopy	May 24	5.00%	**6.3%**			62
Magnetic Resonance Imaging	May 24	5.00%	**7.4%**			55
Neurophysiology	May 24	5.00%	**37.9%**			28
Non-obstetric Ultrasound	May 24	5.00%	4.6%			51
Urodynamics	May 24	5.00%	**7.1%**			76

14. Pathway Benchmarking & Trend – Diagnostics

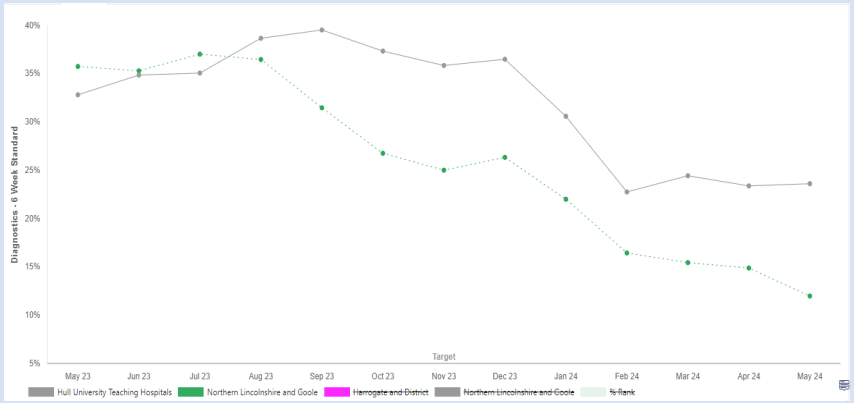
NB: National benchmarking data is a month in arrears due the NHSE publication timetable

Diagnostics – 6 week Performance Standard

Ranking Chart

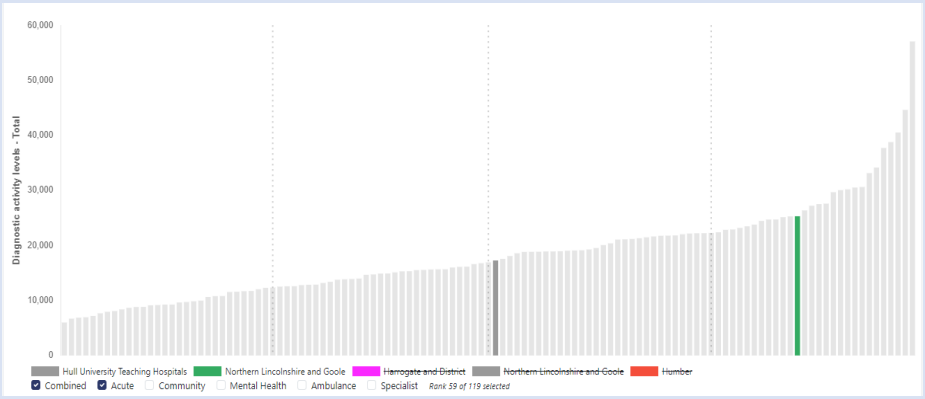


Trend Chart

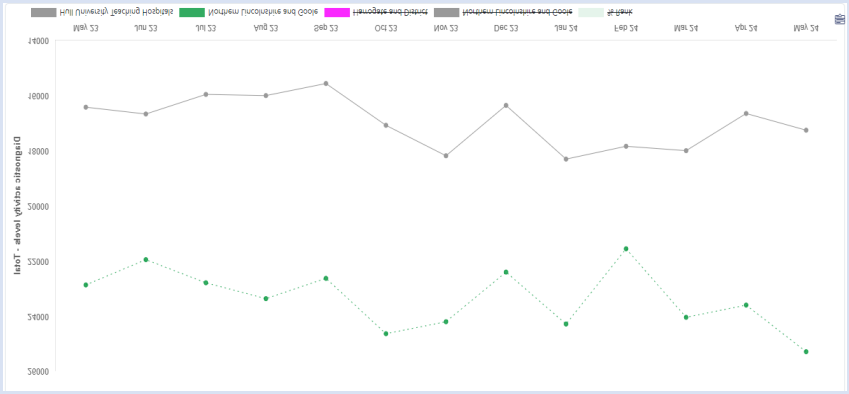


Diagnostics – Activity

Ranking Chart

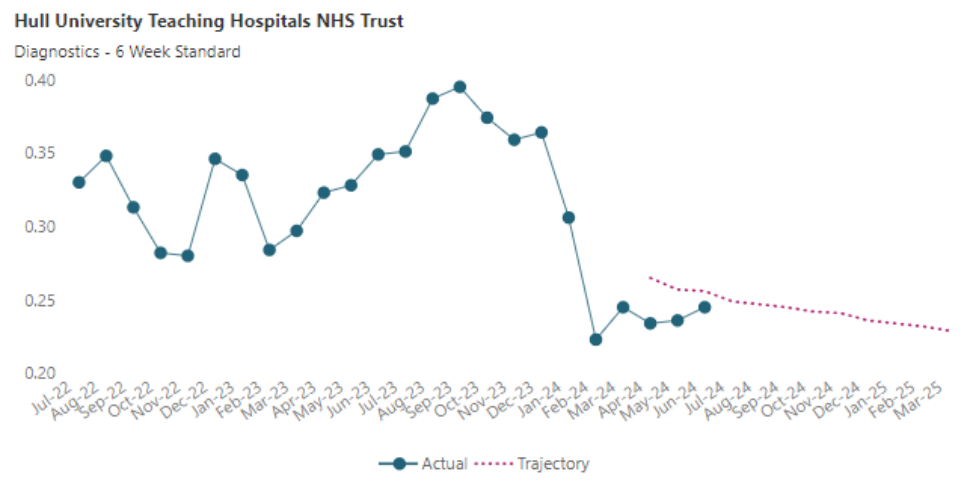


Trend Chart



15. Diagnostic 6 Week Standard - HUTH

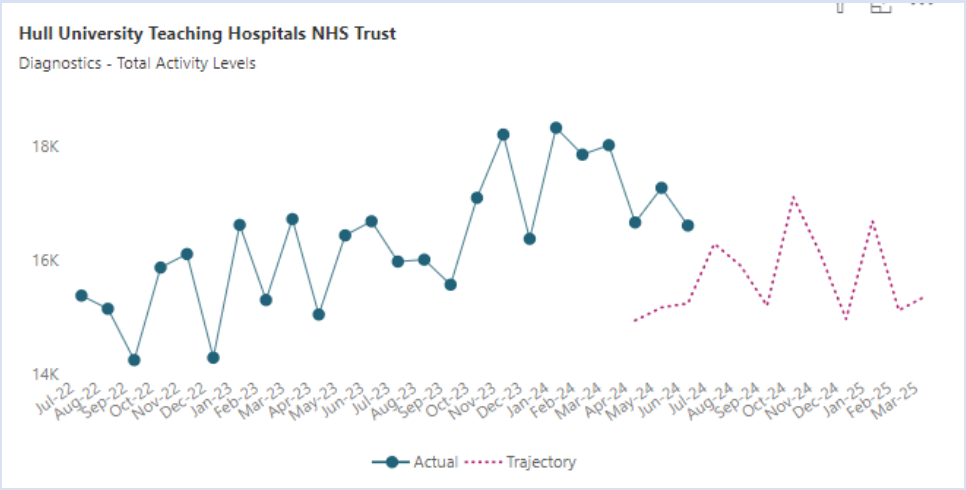
Compliance



Key Themes

- Most modalities at HUTH increased activity levels over 23/24 and into 24/25. Whilst ahead of delivery trajectory, aggregate diagnostic compliance has remained static in recent months.
- Modality level compliance is varied at HUTH versus NLAG, driving a need to equalise waits within the Group.
- The most notable example is DEXA scans at HUTH being a national outlier while NLAG is currently below the <5% target. Enhanced validation of the waiting list for Dexa have been deployed, improvements in recording alignment to national guidance implemented and an internal mutual aid programme to equalise waits within the Group being enacted.

Critical Enabler

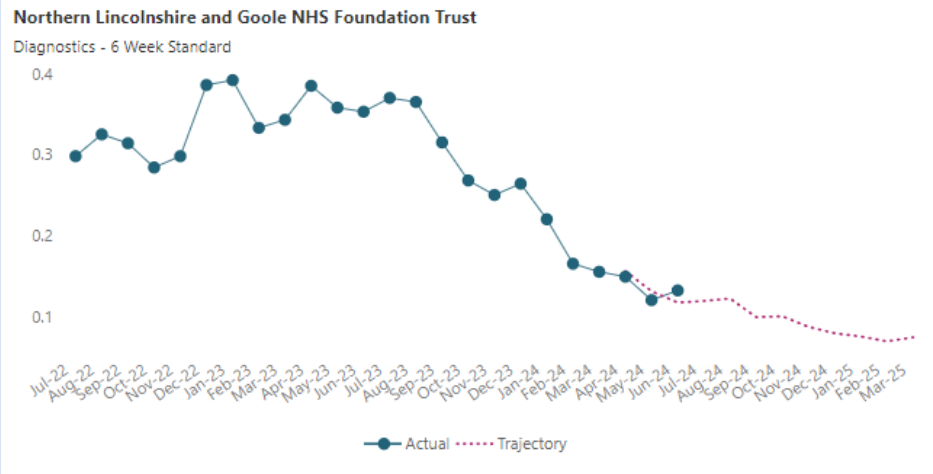


Actions

- Critical actions in place:
  - Services have developed improvement plans to create additional diagnostic activity levels and utilise mutual aid opportunities across the Group, these are due to be presented to the Planned Care Board.
- Dedicated investment case submitted to address DEXA waiting list backlog via increased throughput and testing volume capacity.

16. Diagnostic 6 Week Standard - NLAG

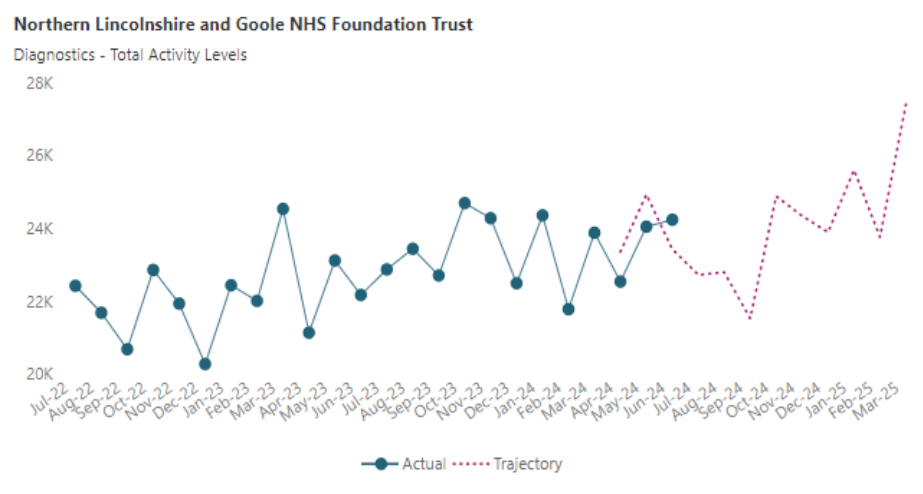
Compliance



Key Themes

- Diagnostic activity levels in most modalities decreasing at NLAG – offset by an increase in imaging activity linked to use of mobile scanners.
- Aggregate (all modality) compliance continues to improve through the increased activity levels in imaging.
- Main pressures are in Audiology, Neurophysiology and Non-Obstetric Ultrasound.
- Imaging activity recording varies at both Trusts. NLAG reports based on body parts scanned, rather than overall scan volume, which leads to NLAG having higher reported activity levels than HUTH. Both practices technically align to national guidance.

Critical Enabler



Actions

- Operating Plan commitments significantly extend diagnostic activity levels in 24/25 and. Further activity stretch plans have been developed to create additional diagnostic activity levels above the annual plan and utilise mutual aid opportunities across the Group. Associated investment plans are due to be presented to Group Cabinet in the first week of July.
- Full clinical review of Audiology completed, and action plan being implemented to improve service delivery.
- To mitigate capacity shortfalls relating to staffing in Neurophysiology on the Southbank enhanced workforce arrangement to allow increase flex of staff across the Group have been deployed to reduce backlog.

17. Pathway Summary – Benchmark Report – Cancer Waiting Times

HUTH

Indicator	Period	Target	🏆	SPC	Last 12 Months	Centile
Cancer 2 Week Wait	May 24	93.00%	**87.5%**			57
Cancer 2 Week Wait Breast Symptomatic	May 24	93.0%	**60.2%**			41
Cancer 28 Day Faster Diagnosis	May 24	75.0%	77.0%			46
Cancer 28 Day Faster Diagnosis - Acute Leukaemia	May 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Brain Tumours	May 24	75.0%	100%			100
Cancer 28 Day Faster Diagnosis - Breast Cancer	May 24	75.0%	94.8%			73
Cancer 28 Day Faster Diagnosis - Breast Symptoms	May 24	75.0%	86.8%			26
Cancer 28 Day Faster Diagnosis - Children's Cancer	May 24	75.0%	100%			100
Cancer 28 Day Faster Diagnosis - Gynaecological Cancer	May 24	75.0%	**52.1%**			14
Cancer 28 Day Faster Diagnosis - Haematological Malignancies	May 24	75.0%	**33.3%**			11
Cancer 28 Day Faster Diagnosis - Head & Neck Cancer	May 24	75.0%	90.7%			94
Cancer 28 Day Faster Diagnosis - Lower Gastrointestinal Cancer	May 24	75.0%	**47.6%**			8
Cancer 28 Day Faster Diagnosis - Lung Cancer	May 24	75.0%	81.0%			50
Cancer 28 Day Faster Diagnosis - Missing or Invalid	May 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Other Cancer	May 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Skin Cancer	May 24	75.0%	99.1%			93
Cancer 28 Day Faster Diagnosis - Testicular Cancer	May 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Upper Gastrointestinal Cancer	May 24	75.0%	91.5%			91
Cancer 28 Day Faster Diagnosis - Urological Malignancies	May 24	75.0%	**53.9%**			39
Cancer 31 Day All Stages	May 24	96.0%	**78.7%**			2
Cancer 31 Day First Treatment	May 24	96.00%	**84.6%**			4
Cancer 31 Day Subsequent Treatment	May 24	96.0%	**71.7%**			5
Cancer 31 Day Subsequent Treatment - Drugs	May 24	96.0%	96.3%			10
Cancer 31 Day Subsequent Treatment - Radiotherapy	May 24	96.0%	**56.8%**			4
Cancer 62 Day All Routes	May 24	85.00%	**57.7%**			18
Cancer 62 Day Consultant Upgrade	Apr 24	85.0%	**35.1%**			4
Cancer 62 Day Screening	May 24	90.0%	**61.7%**			40
Cancer 62 Day Urgent Suspected	May 24	85.00%	**62.8%**			51
Cancer of bronchus; lung	Jan 24	100.0	**113.7**			29

NLAG

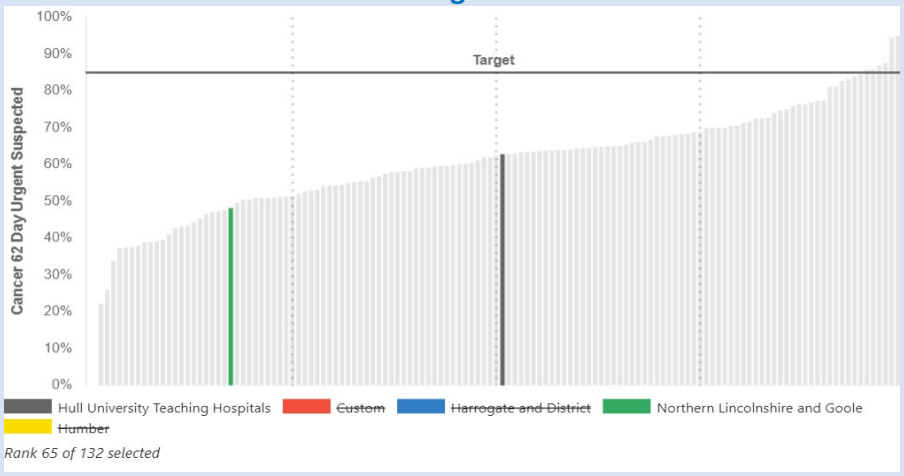
Indicator	Period	Target	🏆	SPC	Last 12 Months	Centile
Cancer 2 Week Wait	May 24	93.00%	94.5%			84
Cancer 2 Week Wait Breast Symptomatic	May 24	93.0%	100%			100
Cancer 28 Day Faster Diagnosis	May 24	75.0%	**71.9%**			19
Cancer 28 Day Faster Diagnosis - Breast Cancer	May 24	75.0%	93.8%			68
Cancer 28 Day Faster Diagnosis - Breast Symptoms	May 24	75.0%	96.2%			74
Cancer 28 Day Faster Diagnosis - Gynaecological Cancer	May 24	75.0%	**62.3%**			37
Cancer 28 Day Faster Diagnosis - Haematological Malignancies	May 24	75.0%	**0.0%**			1
Cancer 28 Day Faster Diagnosis - Head & Neck Cancer	May 24	75.0%	**61.2%**			5
Cancer 28 Day Faster Diagnosis - Lower Gastrointestinal Cancer	May 24	75.0%	**63.7%**			44
Cancer 28 Day Faster Diagnosis - Lung Cancer	May 24	75.0%	**56.4%**			10
Cancer 28 Day Faster Diagnosis - Missing or Invalid	May 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Other Cancer	May 24	75.0%	75.0%			67
Cancer 28 Day Faster Diagnosis - Sarcoma	May 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Skin Cancer	May 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Testicular Cancer	May 24	75.0%	75.0%			28
Cancer 28 Day Faster Diagnosis - Upper Gastrointestinal Cancer	May 24	75.0%	80.6%			57
Cancer 28 Day Faster Diagnosis - Urological Malignancies	May 24	75.0%	**56.4%**			47
Cancer 31 Day All Stages	May 24	96.0%	96.3%			62
Cancer 31 Day First Treatment	May 24	96.00%	97.2%			70
Cancer 31 Day Subsequent Treatment	May 24	96.0%	**94.5%**			47
Cancer 31 Day Subsequent Treatment - Drugs	May 24	96.0%	96.5%			13
Cancer 31 Day Subsequent Treatment - Radiotherapy	May 24	96.0%	-			-
Cancer 62 Day All Routes	May 24	85.00%	**50.4%**			9
Cancer 62 Day Consultant Upgrade	Apr 24	85.0%	**32.3%**			3
Cancer 62 Day Screening	May 24	90.0%	**60.0%**			38
Cancer 62 Day Urgent Suspected	May 24	85.00%	**48.2%**			18
Cancer of bronchus; lung	Jan 24	100.0	**111.7**			34

18. Pathway Benchmarking & Trending – Cancer Waiting Times

NB: National benchmarking data is a month in arrears due the NHSE publication timetable

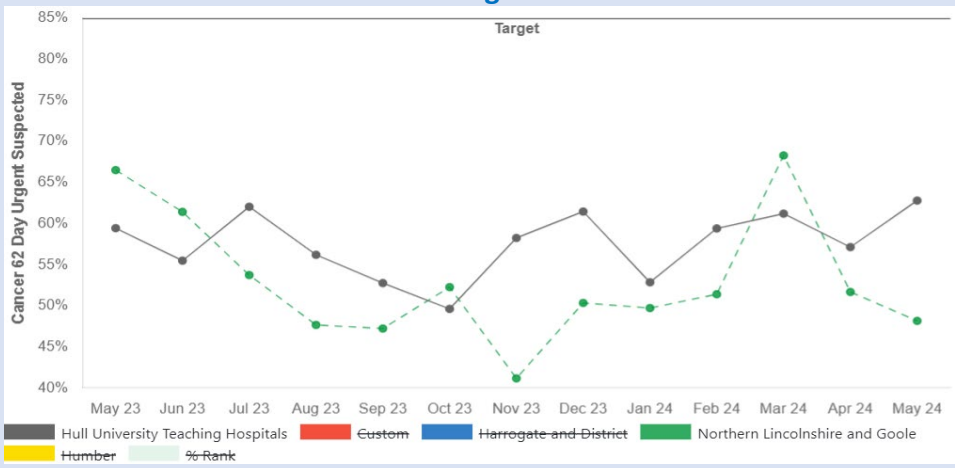
62 Day Performance

Ranking Chart



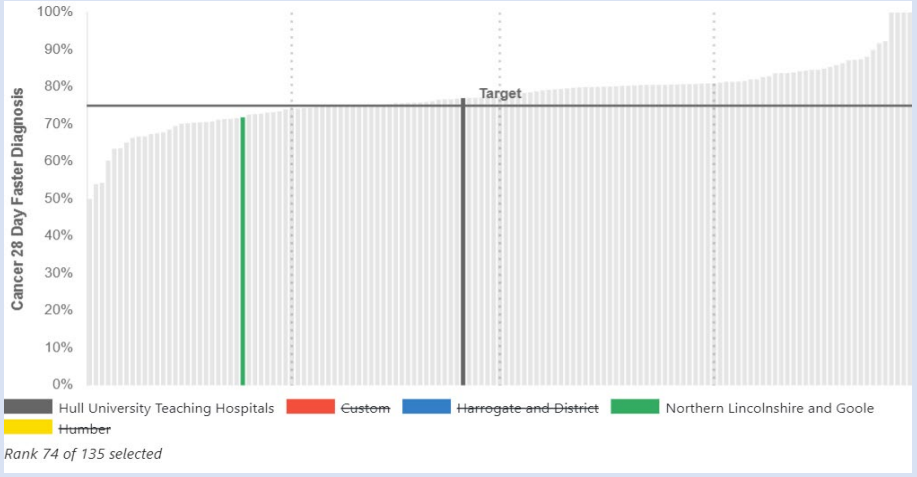
Rank 65 of 132 selected

Trending Chart



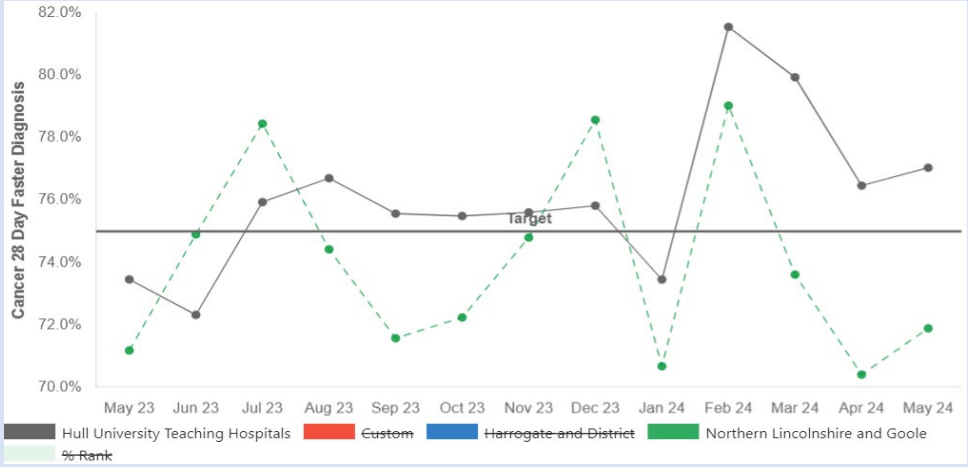
Faster Diagnosis Performance

Ranking Chart



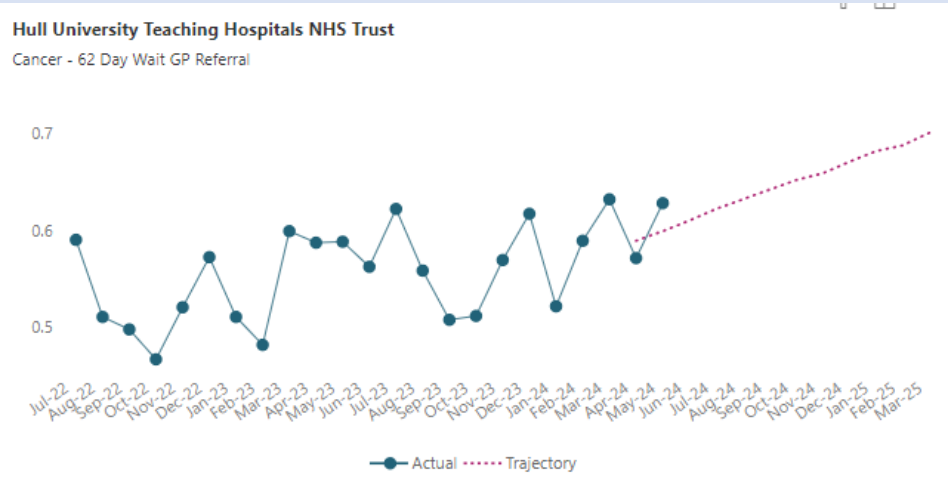
Rank 74 of 135 selected

Trending Chart



19. 62 Day Cancer Performance - HUTH

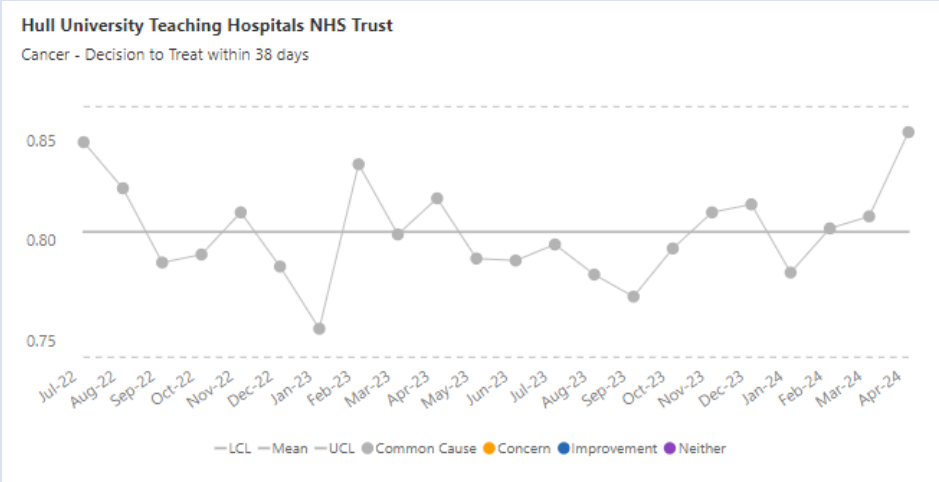
Compliance



Key Themes

- 62.8% performance for May 2024 +5.8% from April 2024
- 48.6% provisional performance for June 2024
  - Breach review as part of BAU DQ prior to month end (3 July 2024)
  - Nav Bronch equipment replaced; still to address pooling of patients to avoid differential waiting times
  - Radiotherapy recovery plan continues (12 months from November 2023) & mutual aid from Lincoln
  - Continued in-sourced capacity for Gynaecology and Urology during 2024/25 Q1
  - Histology TATs - SHYPS TAT Improvement Plan
  - PET CT capacity issues as previously highlighted
  - Late IHTs – Lung, Gynae and Urology: focussed work in Urology within the Group
  - Oncology capacity (vacancies plus increased demand) – clinical prioritisation in Breast, and now Urology
  - Surgical capacity in LGI and Urology (vacancies) & Thoracic (absence plus retirement)
  - 10% increase in Cancer Referrals compared to previous year
  - Improvement in decision to treat by Day 38 to 85%

Critical Enabler

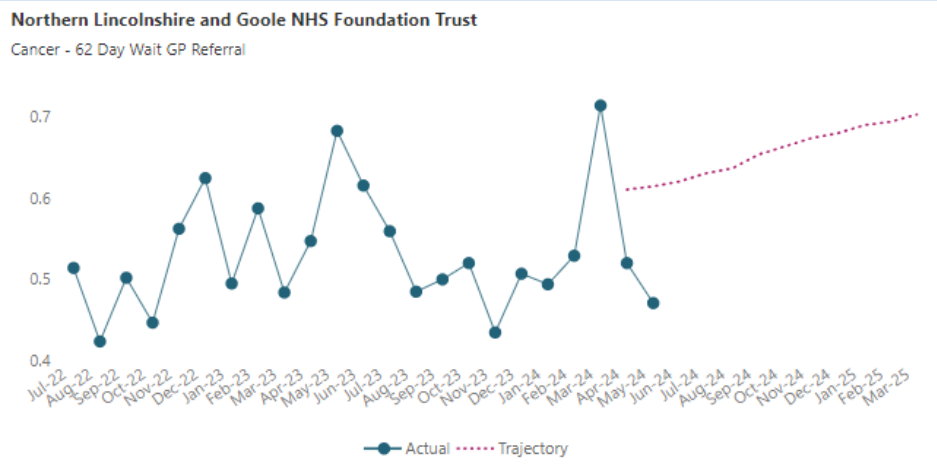


Actions

- HNYCA IPT SOP – embed and review across the Group
- Inter-Group review of the Urology IPTs – urology improvement group extended to cover the Group
- Lung whole pathway review undertaken 28 June 2024 – North and South bank combined event which included LHC CWT guidance consistency, nodule planned surveillance and IHTs
- Plastic Surgery capacity – x2 vacant consultant posts wef mid-April 2024; focussed effort to maintain PTL
- Urology consultant vacancies – impacted by annual leave, significant delays with outpatient and surgical capacity
- Colorectal – improvement focus continues on USC pathway, despite consultant vacancies however poor bowel screening performance is negating the positive effect.
- Bowel screening improvement plan in development.

20. 62 Day Cancer Performance - NLAG

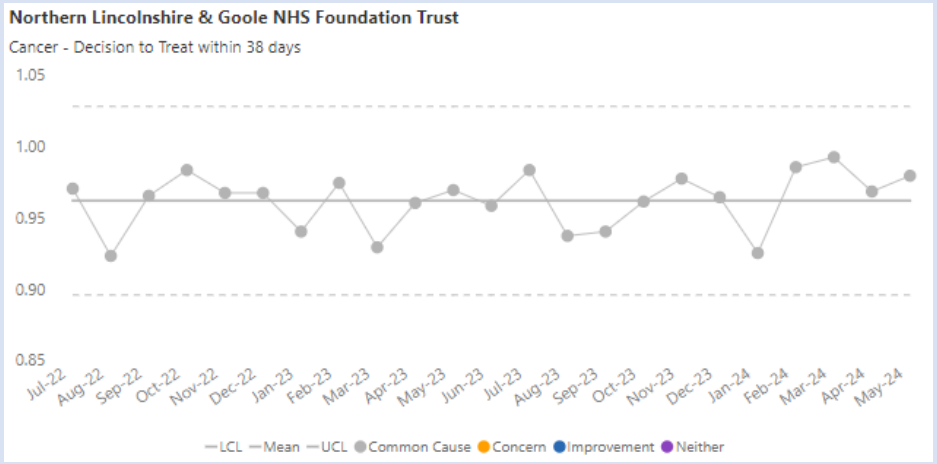
Compliance



Key Themes

- May 24 performance 47.1%
- June 2024 performance (provisional 52.7%)
  - IPT transfer delays continue with impact assessed at between 7-10% only due to breach attribution in Lung & Urology pathways; both have front end pathway delays to be addressed
  - Lung - capacity for OPAs, navigational bronchoscopy, EUS, oncology appointments (to determine surgical vs. oncology treatment). Lung physician vacancies x 2 – in recruitment, previous difficulties and retention issues
  - Urology surgical capacity (vacancy)
  - Gynaecology – OPA and diagnostic capacity issues, plus review of tracking/pathway management underway
  - Histology TATs - % within 10 days and overall TATs being analysed by Path Links

Critical Enabler

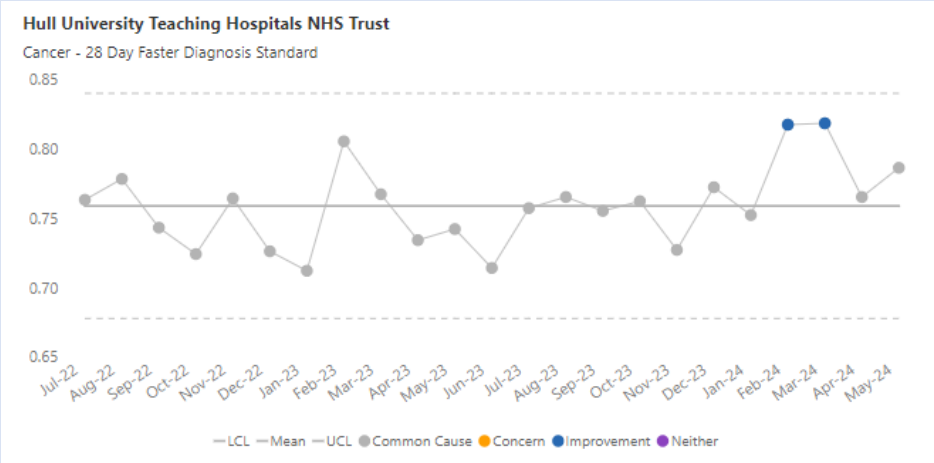


Actions

- Escalation SOP being updated for implementation at NLAG
- Focussed work on IHT process improvements with Lung and Urology as priority areas
- Urology – Improvement group established to use/apply learning from HUTH pathway improvement
- Gynae – improvement plan required to address delays in OPA's to give non-cancer diagnosis before 28 days capacity for outpatients, colposcopy and hysteroscopy needs to match demand.
- Colorectal – review of NSS/STT and LGI pathways being undertaken; identification of non-cancer pathways in USC capacity
- Lung – improvement opportunities identified through workshop which need clinical agreement; vacancies and retention issues for Respiratory Physicians (locums) plus navigational bronchoscopy delays as per HUTH
- Alignment of DQ reports (following Lorenzo implementation at NLAG) across HUTH/NLAG

21. 28 Day Faster Diagnosis Standard - HUTH

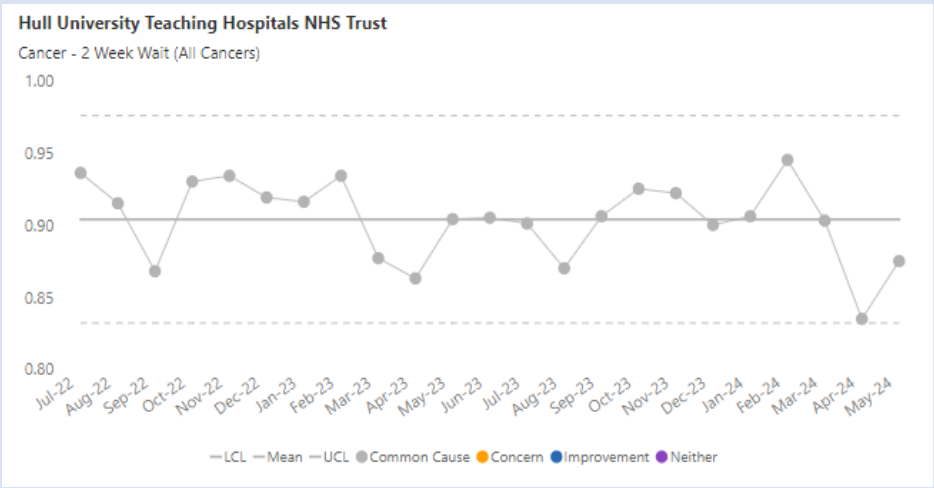
Compliance



Key Themes

- Achieving target for Q1, however:
  - Below target/trajectory in April 2024 with confirmed performance at 76.5%
  - May 2024 – confirmed performance of 77.6%
  - June 2024 – provisional performance of 81.5%
- Bowel screening pathway performance concerns highlighted to Digestive Diseases Care Group Triumvirate

Critical Enabler

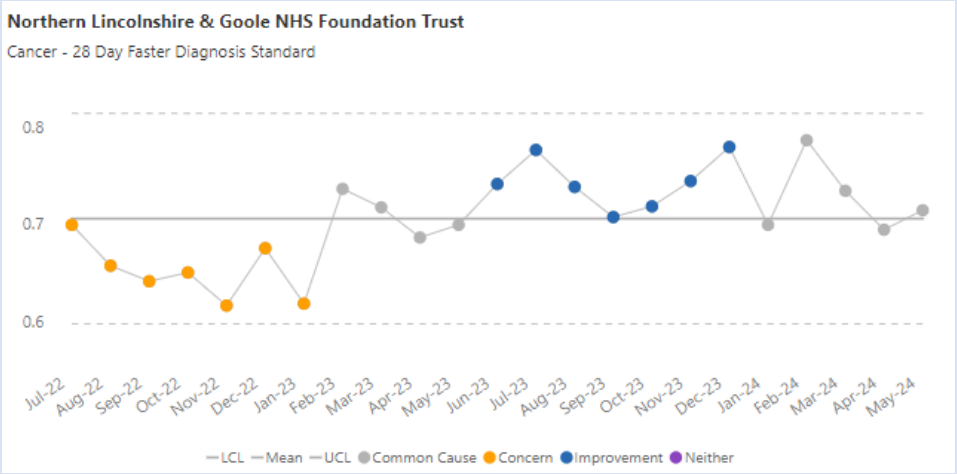


Actions

- FDS Delivery Improvement plans – to sustain performance at least 80% monthly
- Radiotherapy recovery plan mobilised
- Endoscopy recovery plan – post investment improvements required
- Missed opportunities to inform patients earlier (FDS achieved but not communicated the patient)
- Breaches of 1st OPA after Day 28 – Breast and H&N (capacity) & UGI largely patient choice
- Delays in patients accepting diagnostic appointments
- Screening programme performance in LGI – colonoscopy capacity, outcome notifications and patient initiated delays/deferments
- Some complex pathways (accepting the target is 77% to mitigate for these)

22. 28 Day Faster Diagnosis Standard - NLAG

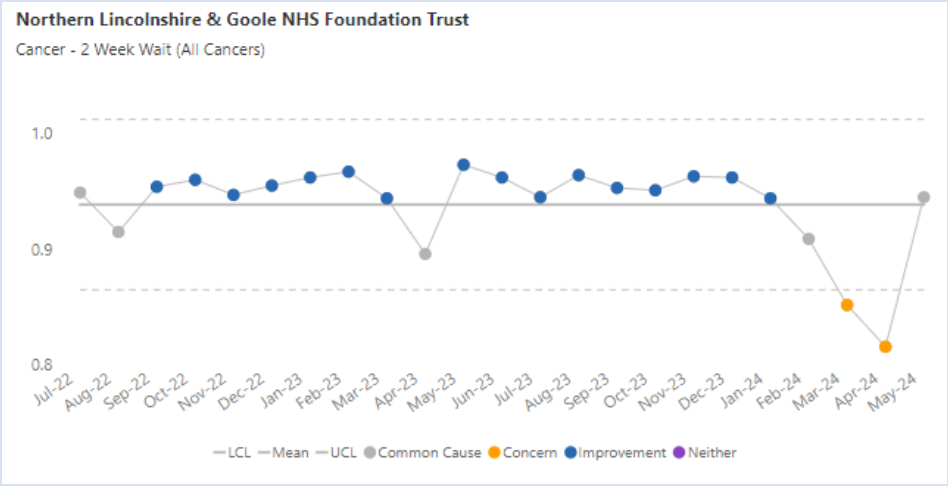
Compliance



Key Themes

- April 2024 below standard at 69.5%
- May 2024 below standard, but improvement at 71.5%
- June 2024 below the standard at 74.3%, but improved on May 2024
- Improvement in USC referral seen by day 14 to 94.5%
- Bowel screening pathway performance concerns highlighted to Digestive Diseases Care Group Triumvirate

Critical Enabler



Actions

- FDS Delivery Improvement plans developed and signed off via the Cancer Delivery Group
- Gynae – pathway capacity issues (1st OPA, colposcopy and hysteroscopy) impacting on FDS
- Head & Neck – repeat diagnostics & histology delays >14 days for reporting
- Lung – clinical workforce (vacancies) & delay in patients receiving diagnosis (non-cancer) before Day 28 (in F2F appt)
- Urology – Improvements in TAT to biopsy (reduced from 30 days to 10 days) has improved Urology performance in June 24; other delays in pathway to be managed through improvement group
- LGI bowel screening service breaches of the standard
- Some complex pathways (accepting the target is 77% to mitigate for these)

23. Pathway Summary – Benchmark Report – Unscheduled Care

HUTH

Indicator	Period	Target		SPC	Last 12 Months	Centile
A&E - 4 Hour Standard	Jun 24	78.00%	**61.0%**			6
A&E - 4 Hour Standard (Type 1)	Jun 24	78.0%	**47.0%**			10
A&E - 4 Hour Standard (Type 2 or 3)	Jun 24	95.0%	**89.9%**			4
A&E - Conversion Rate	Jun 24	25.0%	**25.4%**			17
A&E - DTA to Admission >12 Hours	Jun 24	0.0%	**13.4%**			30
A&E - DTA to Admission >12 Hours#	Jun 24	0.0	**463.0**			25
A&E - DTA to Admission >4 Hours	Jun 24	10.00%	**38.5%**			34
A&E - Left Without Being Seen	May 24	5.00%	**8.2%**			14
A&E - Reattendance Rate	May 24	5.0%	**7.7%**			71
A&E - Time to Initial Assessment	May 24	15.0	**21.0**			11
A&E - Time to Treatment	May 24	60.0	**99.0**			20
A&E - Total Time in A&E	May 24	160.0	**213.0**			21
A&E - Total Time in A&E (Admitted)	May 24	180.0	137.0			88
A&E - Total Time in A&E (Non-Admitted)	May 24	140.0	**231.0**			3
A&E Attendances All	Jun 24	-	13,570			51
A&E Attendances Type 1	Jun 24	-	9,116			64
A&E Attendances Type 3	Jun 24	-	4,454			57
Complaints - Emergency	Q4 21/22	-	0.6			46
Emergency Admissions Type 1	Jun 24	-	3,445			39
Emergency Admissions via A&E	Jun 24	-	3,445			38
Friends & Family A&E Score	Apr 24	85%	**70%**			9
Other Emergency Admissions	Jun 24	-	1,762			14
Total Emergency Admissions	Jun 24	-	5,207			27

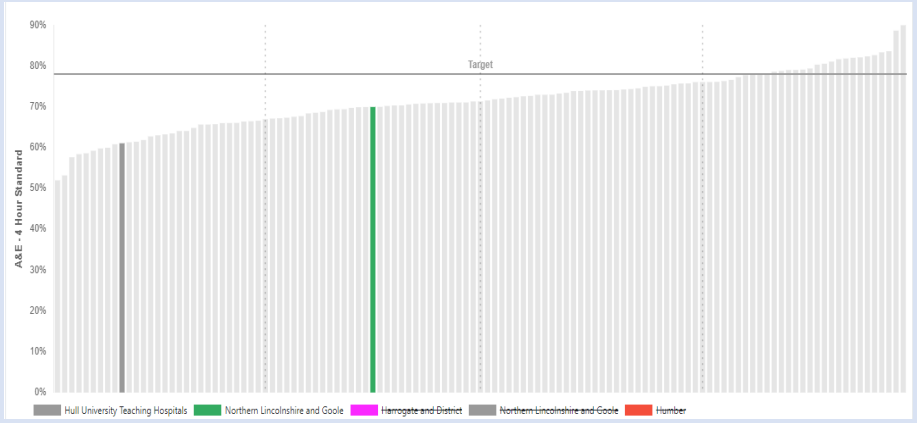
NLAG

Indicator	Period	Target		SPC	Last 12 Months	Centile
A&E - 4 Hour Standard	Jun 24	78.00%	**69.9%**			31
A&E - 4 Hour Standard (Type 1)	Jun 24	78.0%	**45.7%**			7
A&E - 4 Hour Standard (Type 2 or 3)	Jun 24	95.0%	99.3%			67
A&E - Conversion Rate	Jun 24	25.0%	**30.1%**			5
A&E - DTA to Admission >12 Hours	Jun 24	0.0%	**19.1%**			20
A&E - DTA to Admission >12 Hours#	Jun 24	0.0	**923.0**			5
A&E - DTA to Admission >4 Hours	Jun 24	10.00%	**31.4%**			50
A&E - Left Without Being Seen	May 24	5.00%	2.8%			82
A&E - Reattendance Rate	May 24	5.0%	**9.4%**			30
A&E - Time to Initial Assessment	May 24	15.0	**24.0**			7
A&E - Time to Treatment	May 24	60.0	**66.0**			64
A&E - Total Time in A&E	May 24	160.0	**181.0**			57
A&E - Total Time in A&E (Admitted)	May 24	180.0	-			-
A&E - Total Time in A&E (Non-Admitted)	May 24	140.0	**161.0**			59
A&E Attendances All	Jun 24	-	16,024			41
A&E Attendances Type 1	Jun 24	-	8,775			69
A&E Attendances Type 3	Jun 24	-	7,249			37
Complaints - Emergency	Q4 21/22	-	0.7			36
Emergency Admissions Type 1	Jun 24	-	4,831			12
Emergency Admissions Type 3	Jun 24	-	-			-
Emergency Admissions via A&E	Jun 24	-	4,831			12
Friends & Family A&E Score	Apr 24	85%	**84%**			73
Other Emergency Admissions	Jun 24	-	417			70
Total Emergency Admissions	Jun 24	-	5,248			24

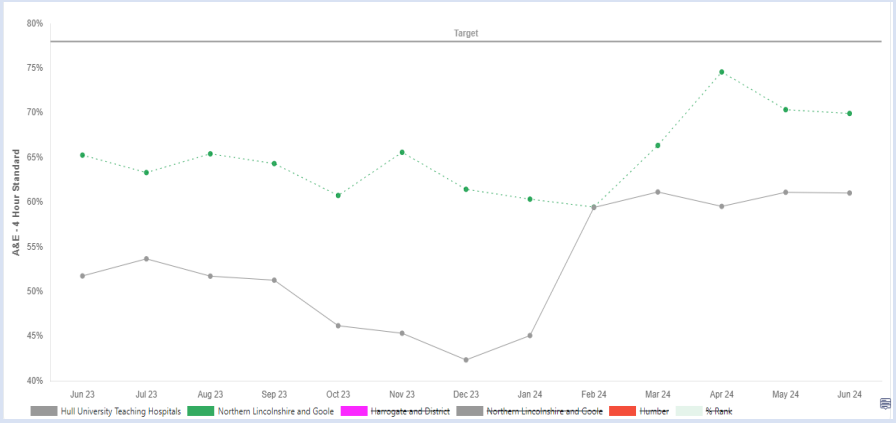
24. Pathway Benchmarking & Trending – Unscheduled Care

A&E - 4 Hour Performance

Ranking Chart

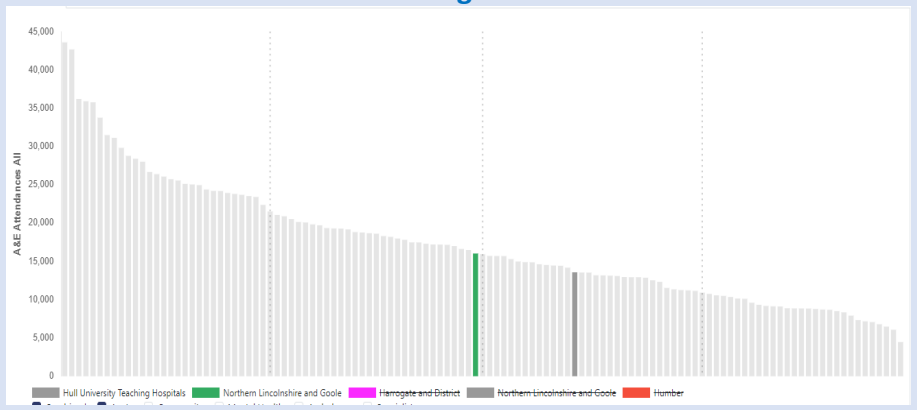


Trending Chart

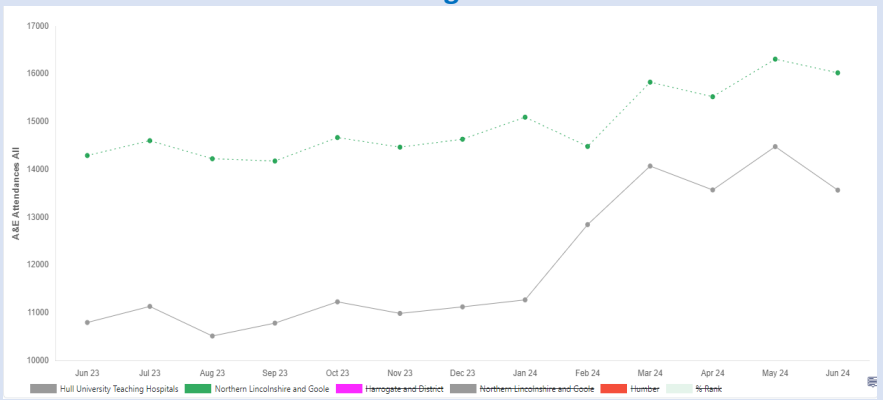


A&E – Attendances

Ranking Chart

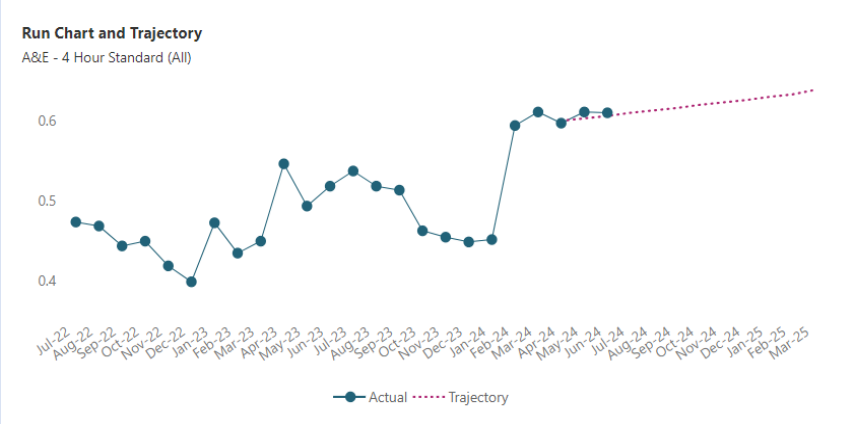


Trending Chart



25. Emergency Care Standards – 4 hour Performance - HUTH

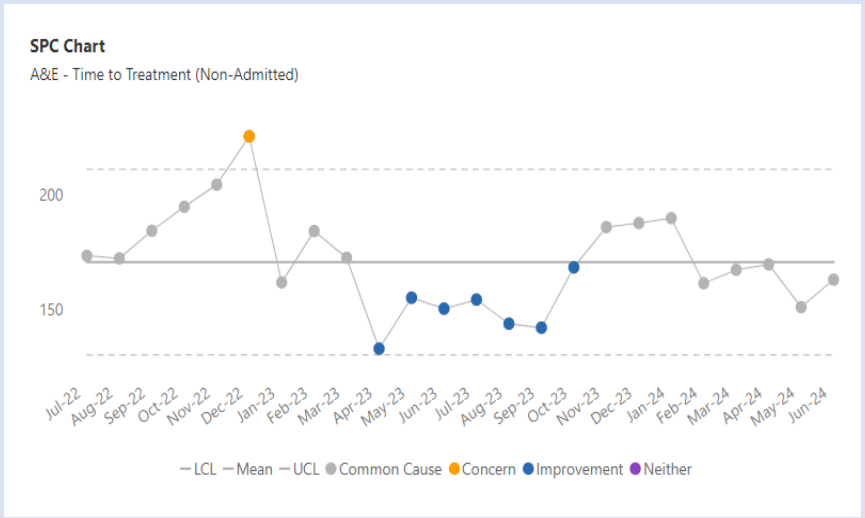
Compliance



Key Themes

- Compliance step change relates to inclusion of HRI UTC in HUTH formal reporting from Feb '23
- Type 1 performance in June of 47% remains significantly ahead of the 24/25 operating plan target of 36.1%.
- Type 3 performance (HRI UTC) has improved from 87.0% in May to 89.9% June, falling short of the 95% target. This coincides with a month on month decrease in attendances, and overall attendances at UTC remain significantly below planned levels.
- HUTH remains within the lowest quartile for patients seen by a clinician within 60 minutes of arrival but has seen improvement in recent weeks. This is outlined in detail in the UEC Deep Dive report.

Critical Enabler



Actions

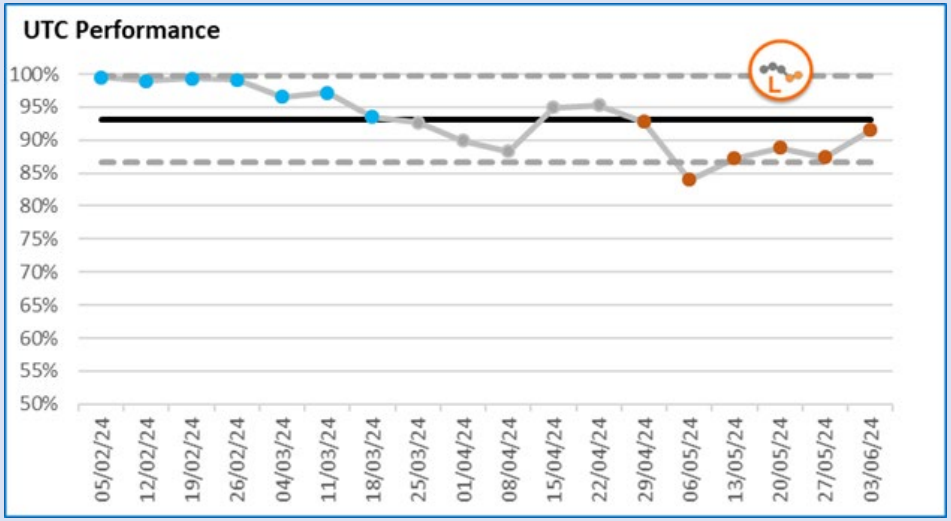
3 critical objectives identified:

1. Reducing non-admitted breaches.
2. Delivery of mean time to first clinician of 30 minutes with a max. of 60 minutes.
3. Improved frailty assessment – patients aged >65 wait twice as long as patients <44.

- Improvement programme in place to improve delivery against the key objectives identified.
- 9am SAS cover implemented in June to support delivery of improved non-admitted performance.
- Work underway to provide increased clinical cover to achieve further sustained improvement, planned to commence September '24. Revised clinical rotas to address intraday C&D imbalance.
- New frailty model implemented, joint communication in place and tracking system implemented on EPR to promote easy identification of this patient cohort.
- Establishment review completed for consultant cover 24/7

26. Emergency Care Standards – Impact of UTC Move to HRI Site - HUTH

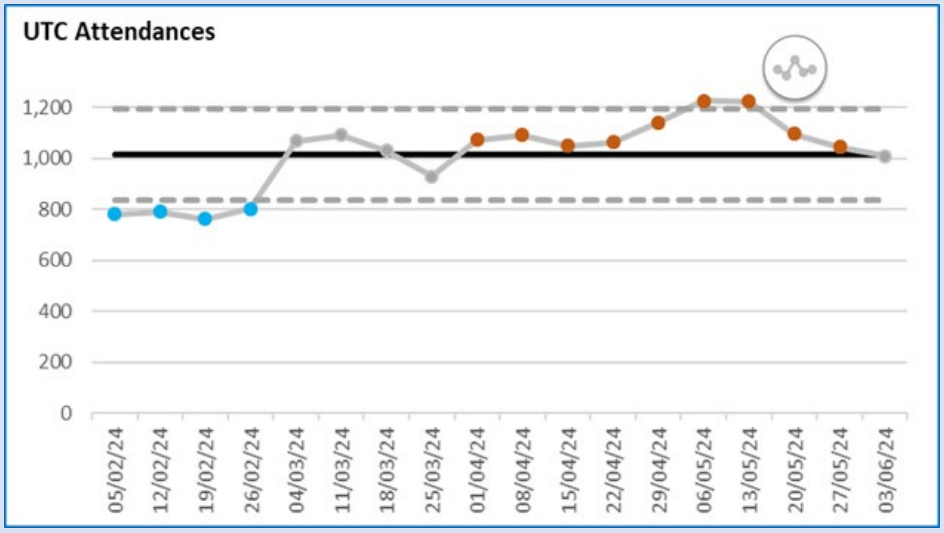
Compliance



Key Themes

- UTC moved from Storey Street to HRI site, opening 05/02/24
- Attendances increased at the UTC from February but have reduced in June. Pathway planning relating to the UTC was predicated on streaming of 85 patients per day. Current streaming rates remain at circa 75 patients per day.
- Type 1 attendances in A&E have reduced by a commensurate volume due to the co-located facility and direct streaming of patients to UTC.
- In addition to the streamed volume from A&E, the HRI UTC was expected to deliver the same baseline activity as Storey Street. To date the UTC is running at c1200 cases lower than that historic baseline.
- Performance at the UTC has deteriorated since go-live on the HRI site from 100% in February 2024 to 89.9% in June2024.

Critical Enabler

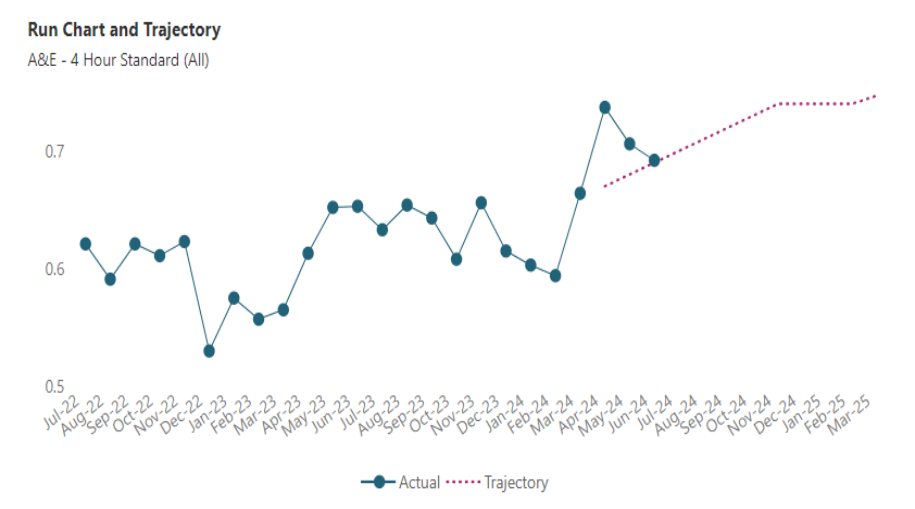


Actions

- The combination of lower than planned activity and compliance via the UTC is impacting on Acute Footprint delivery as detailed in Metric 28 of this paper.
- The Chief Delivery Officer is working with CHCP to agree and deploy an improvement plan.
- Increase in UTC operating hours and streaming volumes to be introduced to improve efficiency of existing diversionary pathways.

27. Emergency Care Standards – 4 hour Performance - NLAG

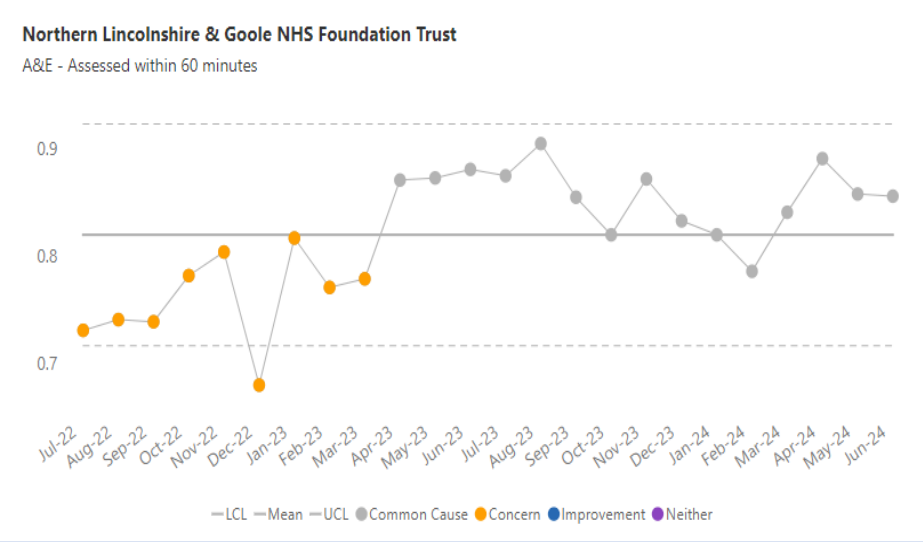
Compliance



Key Themes

- Slight reduction in combined type 1 and 3 performance in month from 70.6% in May to 69.2% in June but NLAG remains consistent with of the 24/25 operating plan target expectation of 69.2%.
- Attendances decreased in month from 16,311 in May to 15,622 in June.
- Total time in A&E increased slightly in month from 234 minutes in May to 241 minutes in June.
- NLaG is slightly above the national mean but within the interquartile range at 66 minutes for A&E 'Time to First Clinician'.

Critical Enabler



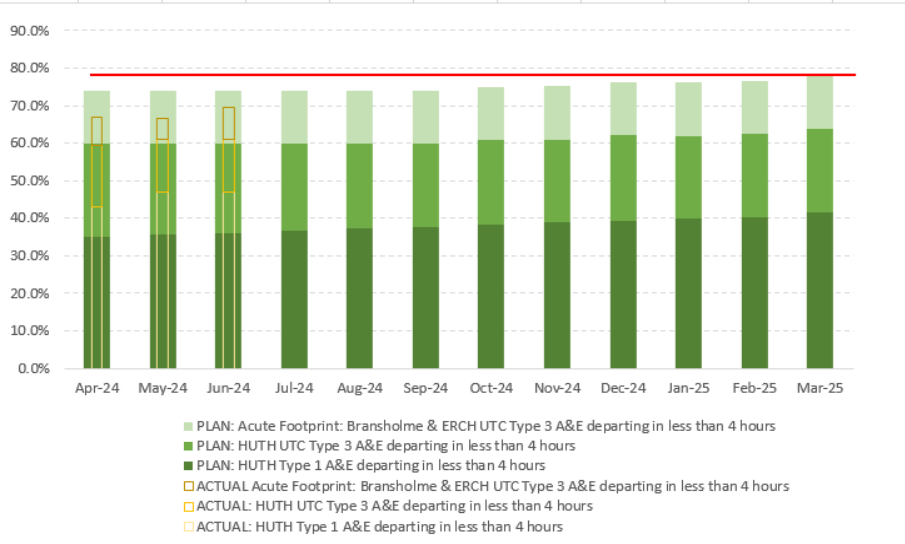
Actions

3 critical objectives identified:

1. Reducing non-admitted breaches.
2. Delivery of mean time to first clinician of 30 minutes with a max. of 60 minutes.
3. Improved frailty assessment – patients aged >65 wait twice as long as patients <44.
   - Demand and capacity review to align workforce to demand underway, vacancies advertised for consultant posts in June.
   - Creation of CDU within ED for specialty assessment diagnostics, and complex cases agreed, implementation planned for September '24 predicting circa 8% increase in 4-hour performance.
   - To improve time first clinician to reduce overall time in A&E, expected when vacant posts appointed to.
   - Discharge rounds reintroduced

28. Acute Footprint Compliance – A&E

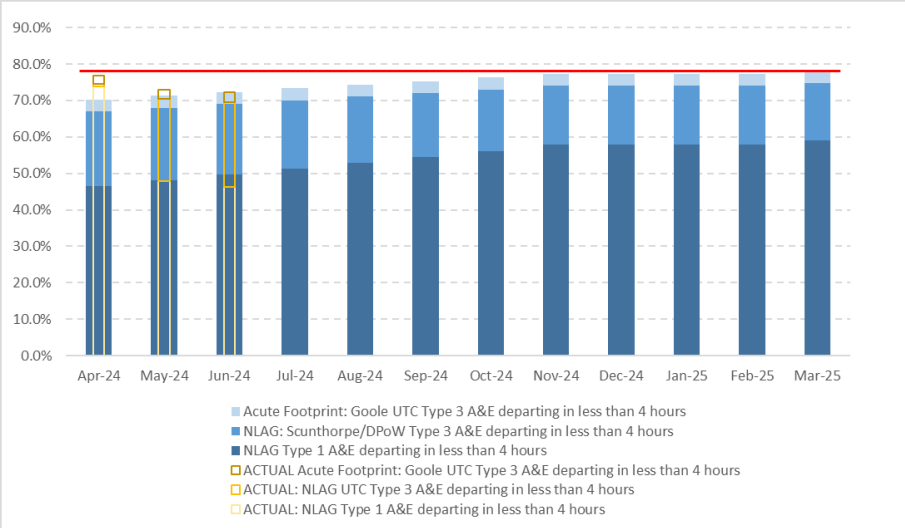
Compliance - HUTH



Key Themes

- As per NEY Region/HNY ICB instruction, 2024/25 trajectories are predicated on 78% delivery as an Acute Footprint by March '25.
- HUTH Type 1 compliance of 46.9% in June significantly exceeded plan (36.1%)
- Type 3 compliance on the HUTH site delivered via the CHCP UTC achieved 89.9% in June. Lower than planned activity volumes and compliance combined to contribute 14.1% to the acute footprint versus a planned contribution of 23.9%.
- Aggregate Type 3 compliance at Bransholme/ERCH was 86.4% contributing 8.4% to acute footprint compliance versus a plan of 14.1%

Compliance - NLAG

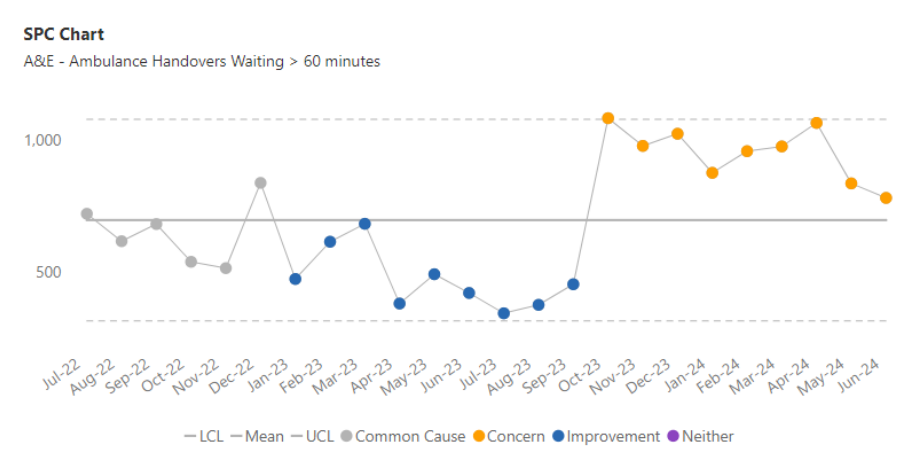


Key Themes

- NLAG Type 1 compliance of 46.2% % in June was below the acute footprint plan of 49.7%.
- Type 3 compliance on the Scunthorpe and DPoW sites delivered 99.3% in June. This provided an acute footprint contribution 21.2%, exceeding the plan of 19.3%,
- Goole UTC operated at 98.0% in June contributing 2.1% to the acute footprint compliance versus a plan of 3.3%

29. Ambulance Handovers >60 minutes - HUTH

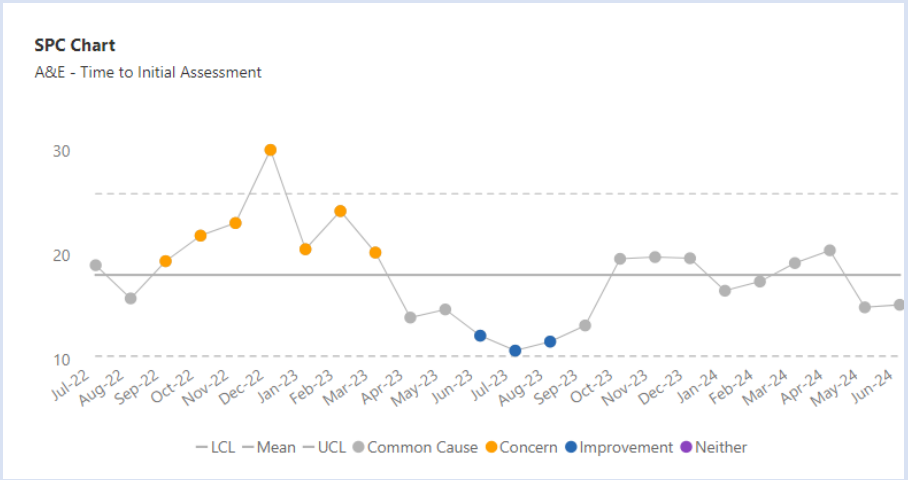
Compliance



Key Themes

- Month on month reduction in handovers >60 continued in June, following a step change in reported volume by EAMS/YAS in October 2023.
- Root cause of handover delays linked to patient volumes in A&E and compression of available assessment spaces. Focus of A&E improvement actions in previous section of this report relating to 4 hour delivery will significantly lower patient volumes in department, in turn decompressing assessment spaces and minimising handover delays.

Critical Enabler

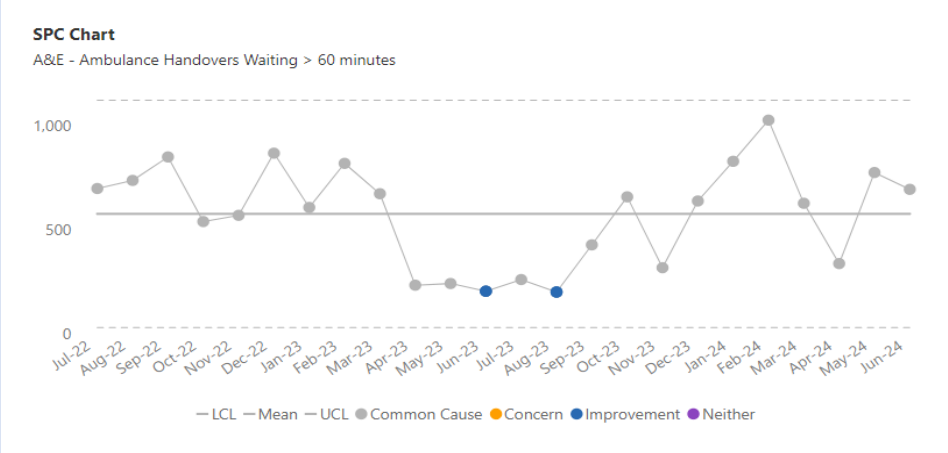


Actions

- Time to clinical assessment remained at 15.0 minutes in June, meeting the national target. This improvement provides early evidence of impact regarding the 3 A&E improvement objectives laid out on pages 26 and 28 of this report
- Triggers and Escalation/SOP for ambulance handovers to be reviewed and adapted linked to national OPEL system, enabling 30-minute Cat 2 responses for YAS.
- Work with YAS to bring forward clinical assessment through proposing changes to current practice.

30. Ambulance Handovers >60 minutes - NLAG

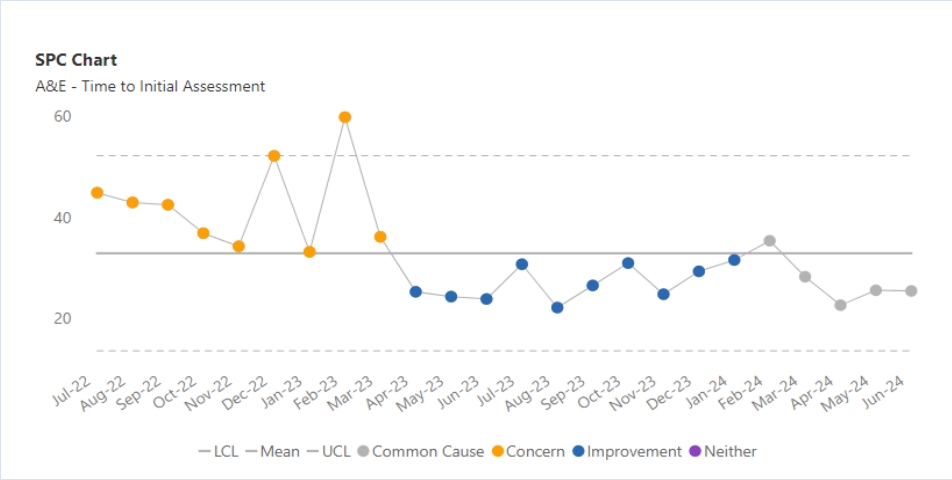
Compliance



Key Themes

- In month improvement in performance in ambulance handovers from 776 in May to 695 in June.
- Time to initial assessment has slightly improved from 26 minutes in May to 25 minutes in June.
- Enabling actions focus on reducing patient volumes in A&E. Actions in previous section of this report relating to the 4 hour target will significantly lower patient volumes in department, increase assessment space availability and enable rapid handover.

Critical Enabler



Actions

- Rapid Assessment and Treatment (RAT) model to be embedded to reduce waiting time to be seen.
- Audit of current practices planned to ensure handover principles are being adhered to. Working toward zero tolerance of >45-minute handover, aim to deliver 100% ambulance handovers under 45min and 80% under 30 minutes.
- Improvement of flow/ LOS through Discharge rounds in wards will reduce congestion.
- Impact and timelines for recovery programme being finalised with system partners. Trajectory with incremental benefits will be presented in the next iteration of this report.

31. No Criteria To Reside - HUTH

Compliance	NCTR number Under development Aligned data provision being developed. NLAG historically reported lost beddays, whereas HUTH reporting occupied beds	**Key Themes**
Critical Enabler	Trending by each pathway	**Actions**

32. No Criteria To Reside - NLAG

Compliance	Under development Aligned data provision being developed. NLAG historically reported lost beddays, whereas HUTH reporting occupied beds	**Key Themes**
Critical Enabler		**Actions**

33. Discharge Ready Date - HUTH

Compliance	% Achieving DRD Under development	**Key Themes**
Critical Enabler		**Actions**

34. Discharge Ready Date - NLAG

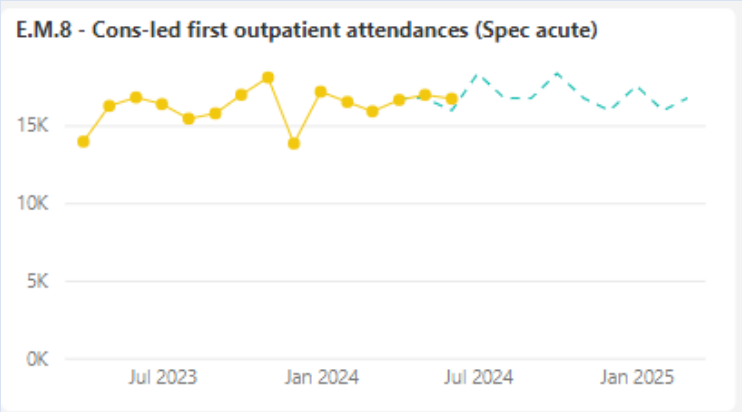
Compliance	Under development	**Key Themes**
Critical Enabler		**Actions**

35. Activity

HUTH

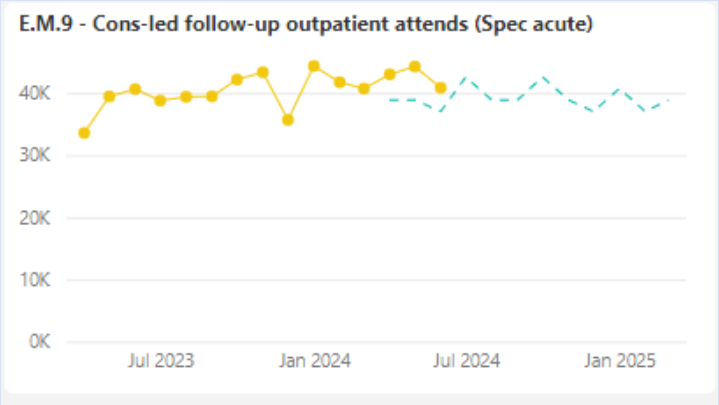
New Outpatient Attendances vs Plan

YTD New consultant-led activity is above plan at +91.



Follow up Outpatient Attendances vs Plan

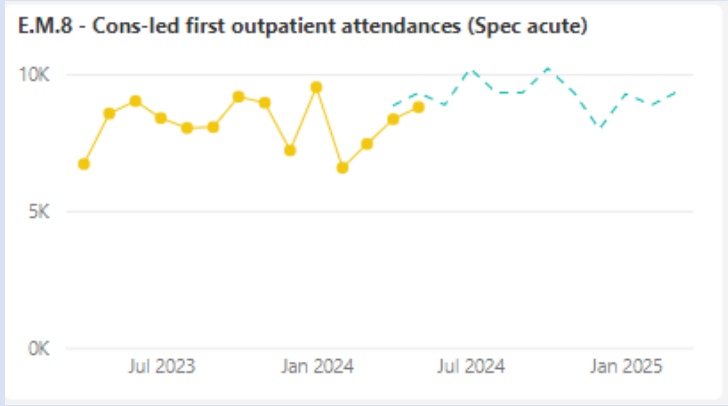
YTD Follow up activity is above plan +9,356



NLAG (data shown to Month 2)

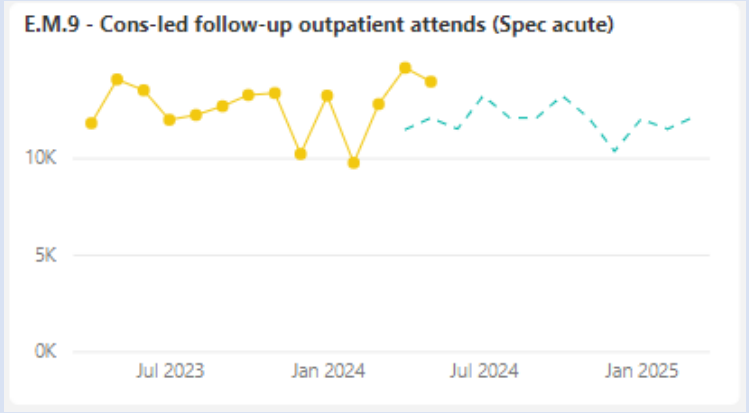
New Outpatient Attendances vs Plan

YTD New consultant-led activity is below plan at -1,009.



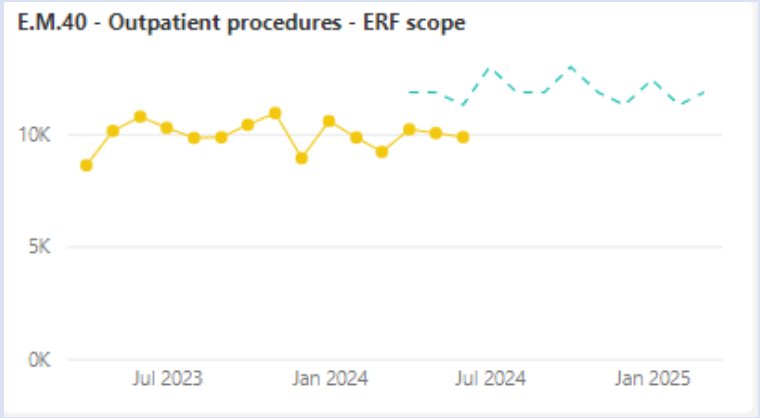
Follow up Outpatient Attendances vs Plan

YTD Follow up activity is above plan +5,158.



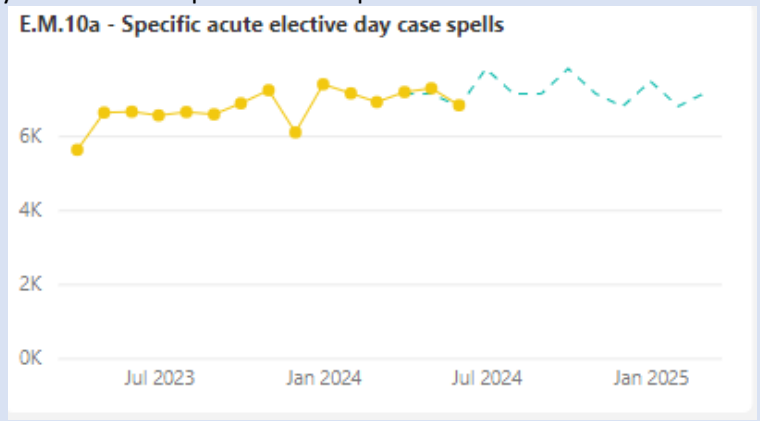
Outpatient Procedures vs Plan

YTD Outpatient procedure is under plan by -3,600. Action is being taken by the RTT Delivery Group to improve the recording of outpatient attendances with procedures.



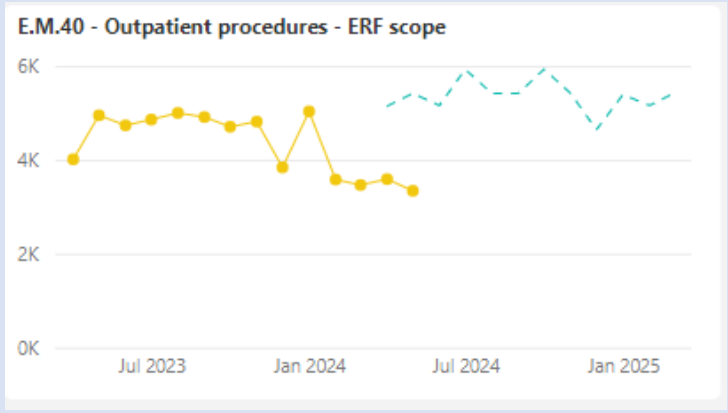
Day Case Admissions vs Plan

YTD Day case elective spells is above plan at +197.



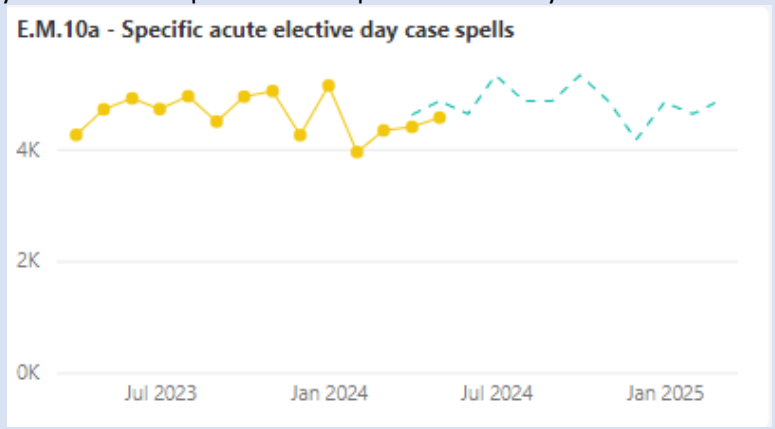
Outpatient Procedures vs Plan

YTD Outpatient procedure is under plan by -3,632. Action is being taken by the RTT Delivery Group to improve the recording of outpatient attendances with procedures.



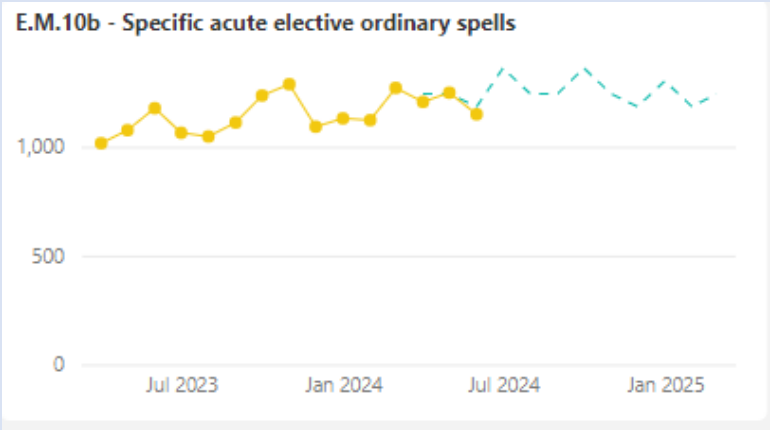
Day Case Admissions vs Plan

YTD Day case elective spells is below plan -516 to May.



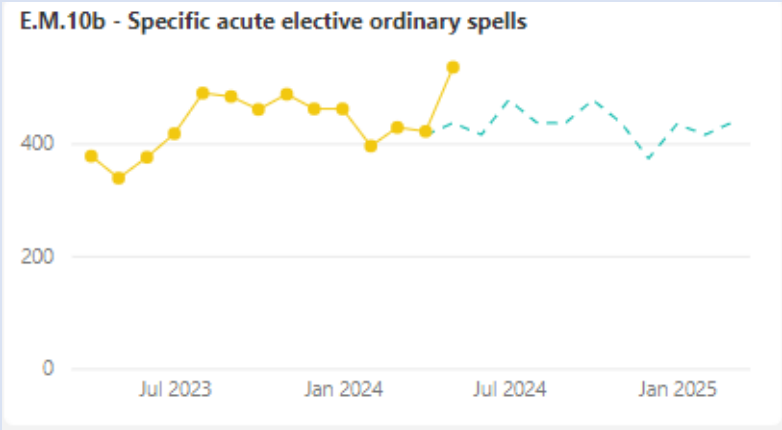
Elective Admissions vs Plan

YTD Inpatient spells is below plan at -32.



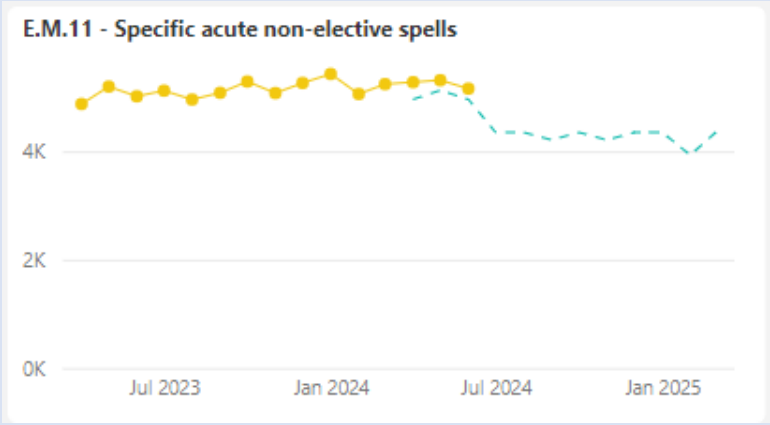
Elective Admissions vs Plan

YTD Inpatient spells is above plan +106 to May, however data is subject to further evaluation of correct operational recording of intended management (Daycase versus zero LOS inpatient)



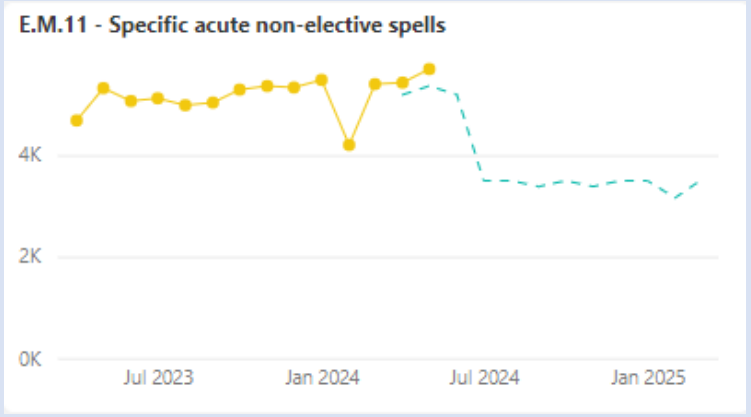
Non-Elective Admissions vs Plan

YTD Non-elective spells +503 over plan.



Non-Elective Admissions vs Plan

Non-elective spells above plan YTD.



36. Elective Recovery Fund - HUTH

	ERF Performance (%)			
Activity Category	**Apr**	**May**	**Jun**	**YTD**
DAYCASE	105%	108%	108%	107%
ELECTIVE	102%	104%	95%	100%
OP FIRST ATTENDANCE	112%	115%	118%	115%
OP FIRST PROCEDURE	110%	107%	114%	110%
OP F/UP PROCEDURE	156%	153%	156%	155%
Total	**108%**	**110%**	**107%**	**109%**

The reported ERF positon is based on the early month 3 information against the ERF baseline 2019/20 updated for the new tariff.
The Trust has assumed that the baseline will be profiled on working days and therefore this may change when the national information is available.
There have been some changes made to the ERF calculation for 2024/25 and whilst we have tried to replicate the methodology, this may need some amendments when we receive the national reports to ensure consistency.

37. Elective Recovery Fund - NLAG

	ERF Performance (%)			
	Apr	**May**	**Jun**	**YTD**
DAYCASE	113%	112%	121%	115%
ELECTIVE	97%	104%	119%	106%
OP FIRST ATTENDANCE	96%	110%	106%	104%
OP FIRST PROCEDURE	90%	95%	87%	91%
OP F/UP PROCEDURE	67%	61%	66%	65%
Total	**100%**	**105%**	**111%**	**105%**

Notes

This data is an early pull of data and as such is not fully coded and may omit some clinics/discharges that were cashed up late.

This data is from the new Insource Data Warehouse and contains some known DQ errors.
This data will not fully match to the SUS national position, as this the SUS position is being generated through the old Data Warehouse to avoid the known errors.

Known errors are:

- Length of stay is overstated where a second or subsequent critical care stay exists, this may overstate excess bedday value.
- Nurse led activity is being treated as Consultant led due to some errors in clinic set up in implementation. A call is being logged to get this addressed.

Quality Performance Metrics

Humber Health Partnership

July 2024

United By Compassion: Driving For Excellence

Highlights and Lowlights

NHS Humber Health Partnership

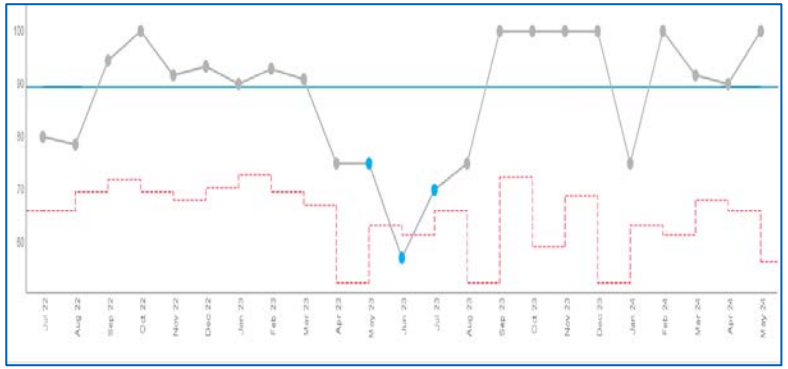
Note: The Quality metrics incorporation to the Group IPR remains in progress, with metrics reported at each individual Trust level in transition and to Quality and Safety Committee in July 2024.

	HUTH	NLAG
Highlights	• VTE there has now been three months of improved compliance at HUTH for the period April to June 2024. • Falls rate trend reduction remains. • Complaints in May and June 2024 have reduced, in line with a reducing trend. • PALS timeliness of completion has improved from Jun 2023 and now is static follow the control limit revision.	• Falls rate trend reduction remains. • HSMR is 94.77, lower again this month • SHMI rate is 1.0039, the lowest it has been in recent history.
Lowlights	• SHMI is 1.1535 and sits in the 'higher than expected' range with 12 other Trusts. Correlating conditions include Fracture of neck of femur (hip), Secondary malignancies and Septicaemia (except in labour). This is subject to targeted work as part of the Mortality Improvement Group. • HSMR value is 111.33 for the rolling 12 months, improving gradually. • Hospital Acquired Pressure ulcer rates have increased in June as the teams have targeted improved reporting which has resulted in an increase in reporting of category 1 pressure ulcers. • IPC-rises in E coli and C difficile. Action plans are in place, with increase in C difficile linked to new reporting requirements since April 2024.	• The SHMI condition of Secondary malignancies is classed as 'higher than expected', and is subject to targeted work as part of the Mortality Improvement Group. • National Patient Safety Alert for Entrapment risk with equipment remains open. Plans to collaborate across the group continue. • VTE method of measurement from ePMA rather than WebV since migration to Lorenzo has resulted in a drop in the performance show, subject to some mapping and coding changes that are ongoing. Improvement seen and CMIO leading this change process. • MSSA bacteraemia rate is higher than expected in June 2024. Post Infection Review (PIR) investigations are being undertaken. • There was an incident of MRSA bacteraemia in June 2024, with PIR investigation.

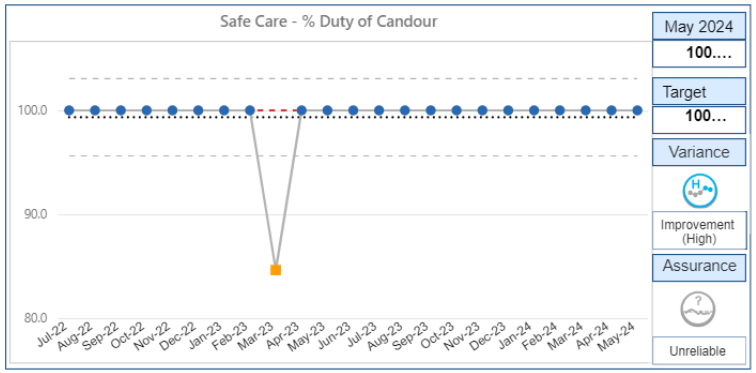
Duty of Candour and Patient Safety Alerts

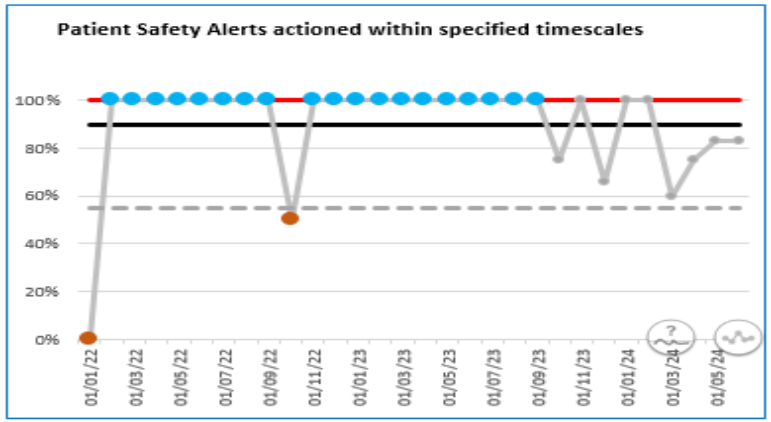
Humber Health Partnership

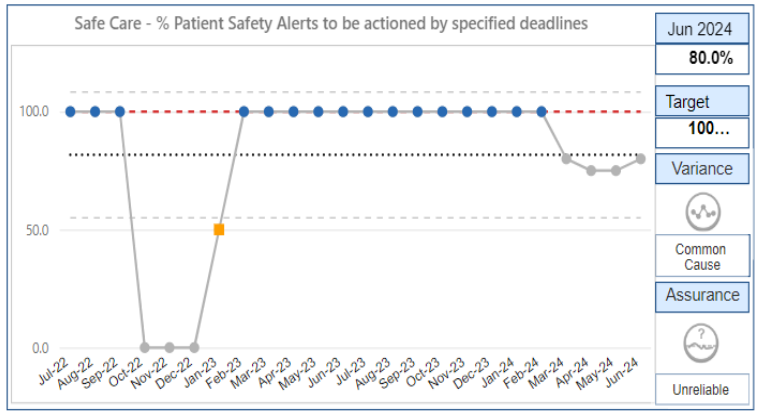
HUTH



NLAG







Duty of Candour

- HUTH: Compliant rates for all incidents meeting criteria are below the expected standard.
- Reviewing data underpinning duty of candour compliance reporting to ensure this appropriately reflects the written response.
- NLAG: 100% for June 2024 for the proportional investigation and PSII/SI casework.

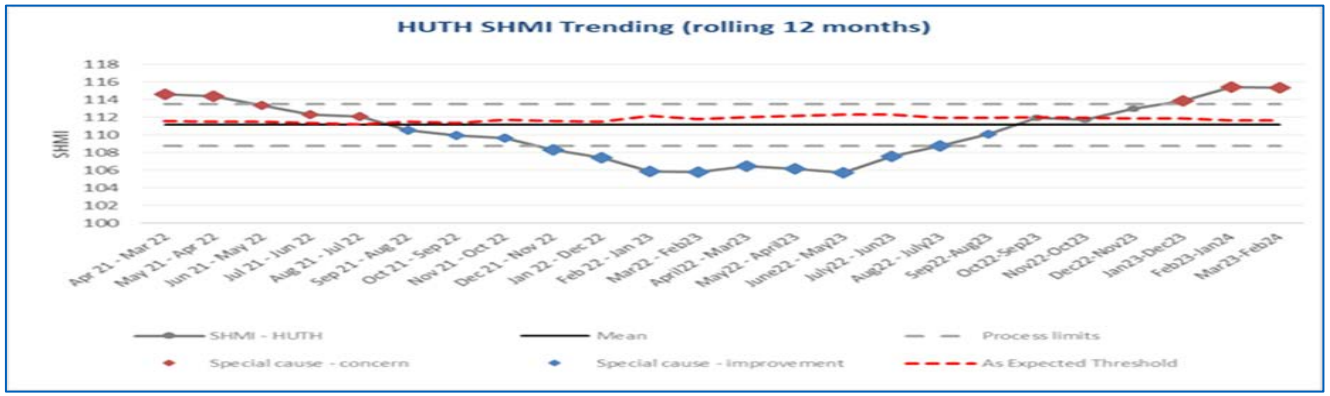
Alignment of monitoring and reporting processes across the Group is underway, with focus on training all teams to a high standard.

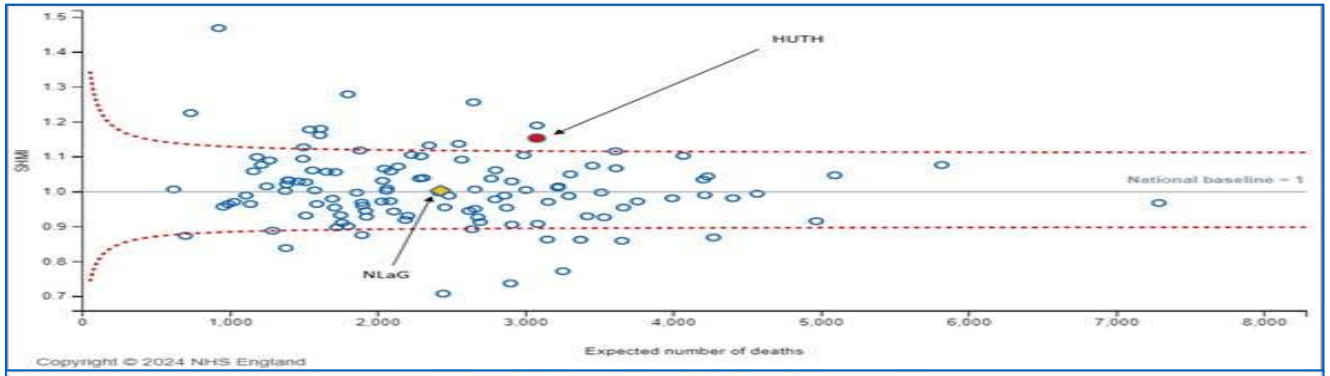
Patient Safety Alerts

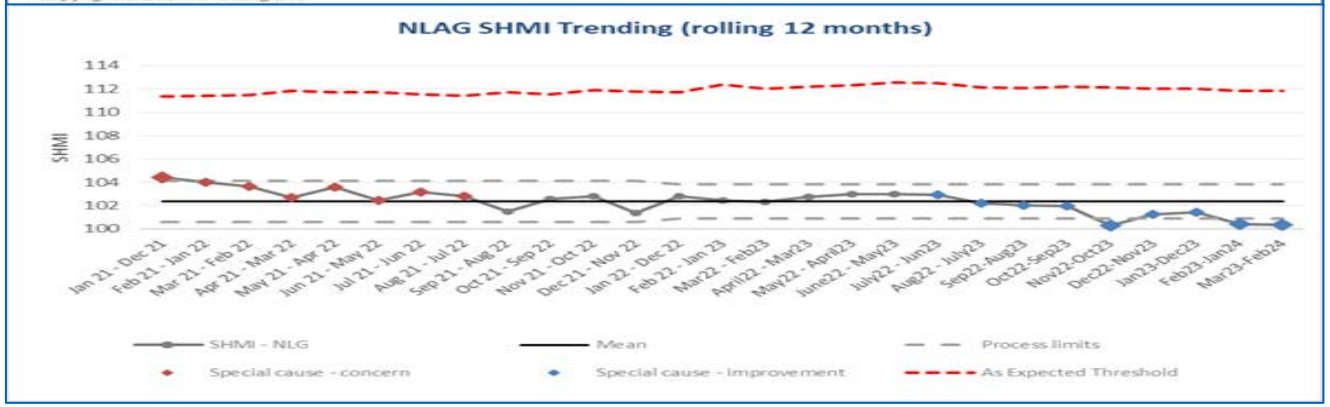
- The one Patient Safety Alert that remains open is in relation to Medical beds trolleys bed grab handles and lateral turning devices: risk of death from entrapment or falls. This breached the deadline of 1 March 2024 across both Trusts, consistent with an ICB working group overseeing progress with this alert.

Mortality – SHMI

Humber Health Partnership







SHMI values include the episode of care and 30 days following discharge survival and deaths risk ratings.

HUTH is identified as having a 'higher than expected' SHMI, with an overall SHMI of **1.1535**. This is lower than last month's value of 1.1544.

NLaG is identified as having a 'as expected' SHMI, with an overall SHMI of **1.0038**. This is lower than last month's value of 1.0039.

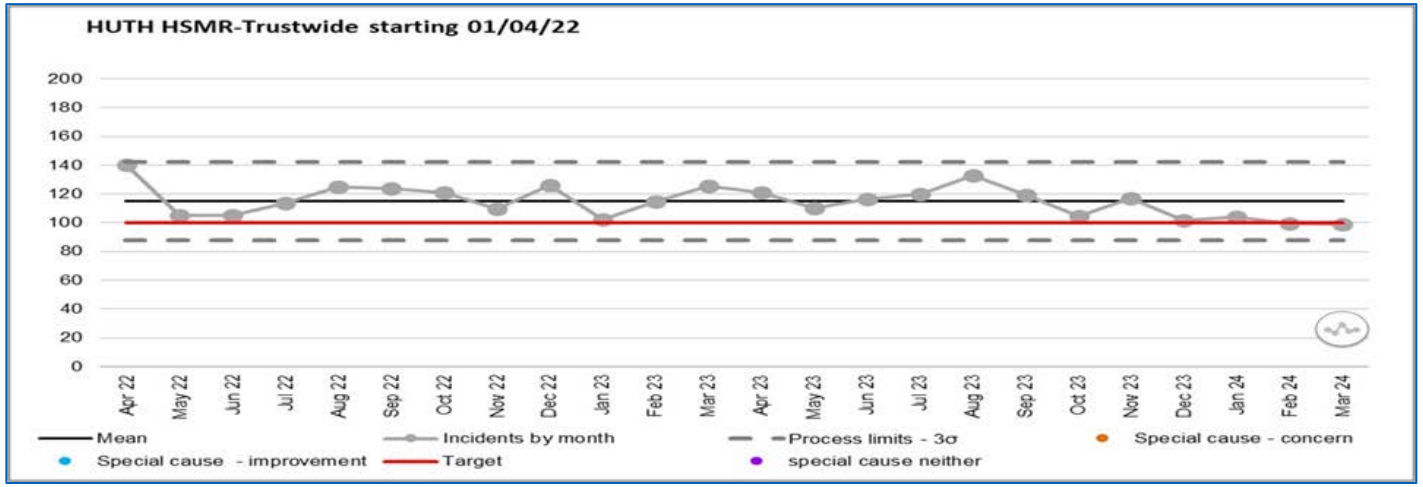
The latest SHMI values for each site are:

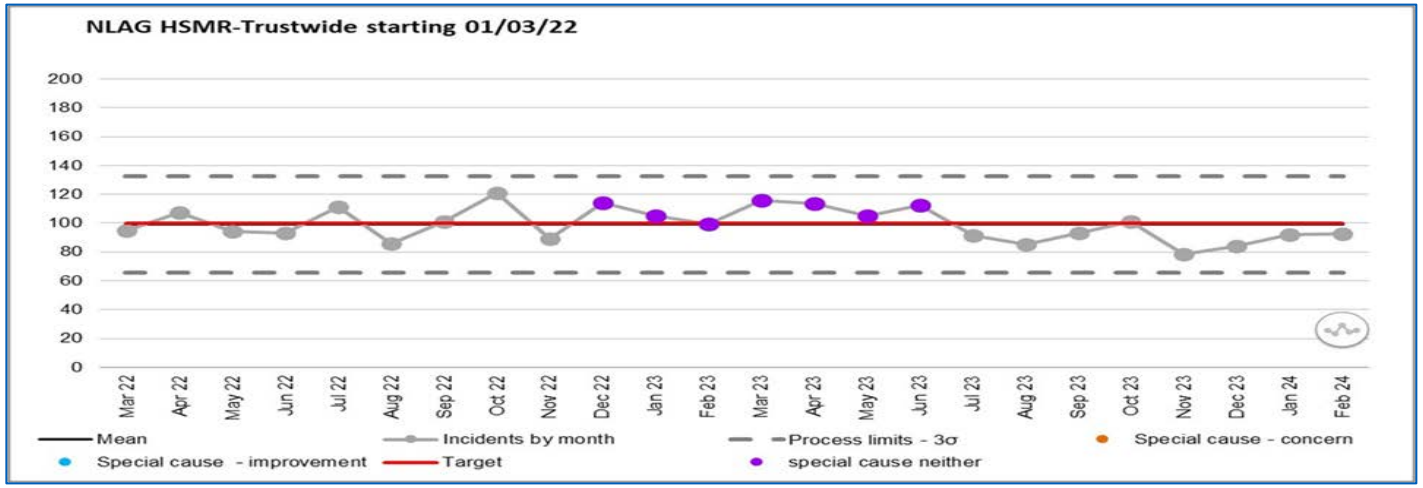
- Castle Hill – 1.3140; 'higher than expected' (previously 1.3139 and 'higher than expected')
- Hull – 1.1080; 'as expected' (previously 1.1083 and 'as expected')
- Grimsby – 0.9869; 'as expected' (previously 0.9904 and 'as expected')
- Scunthorpe – 1.0258; 'as expected' (previously 1.0177 and 'as expected')
- Goole – insufficient activity for SHMI to be calculated

For the conditions for which a SHMI is calculated by NHS Digital:

- **HUTH** is identified as having a **higher** than expected SHMI for:
  - Fracture of neck of femur (hip)
  - Secondary malignancies
  - Septicaemia
- **NLaG** is identified as having a **higher** than expected SHMI for Secondary malignancies
  - Targeted work around these three (and other areas) is in progress.
- **NLaG** is identified as having a **lower** than expected SHMI for Acute bronchitis
- All other diagnosis group specific SHMI values are 'as expected' for both trusts.

Mortality HSMR





Humber Health Partnership

HSMR is a risk adjusted mortality index for a basket of 56 diagnosis groups. The risk adjusted tool uses 100 as the national baseline, focusing on the inpatient episode, so in hospital risk of death.

HUTH

- HSMR data extracted from CHKS shows the Trust's rolling 12 month HSMR value is 111.33 in March 2024 and has been decreasing since November 2023. There has not been a data release to refresh this measure since last month.
- HRI site admitted patients have a ratio of 108 and CHH has a ratio of 125.92. This correlates with SHMI data site variances. (CHH has Oncology services)

NLAG

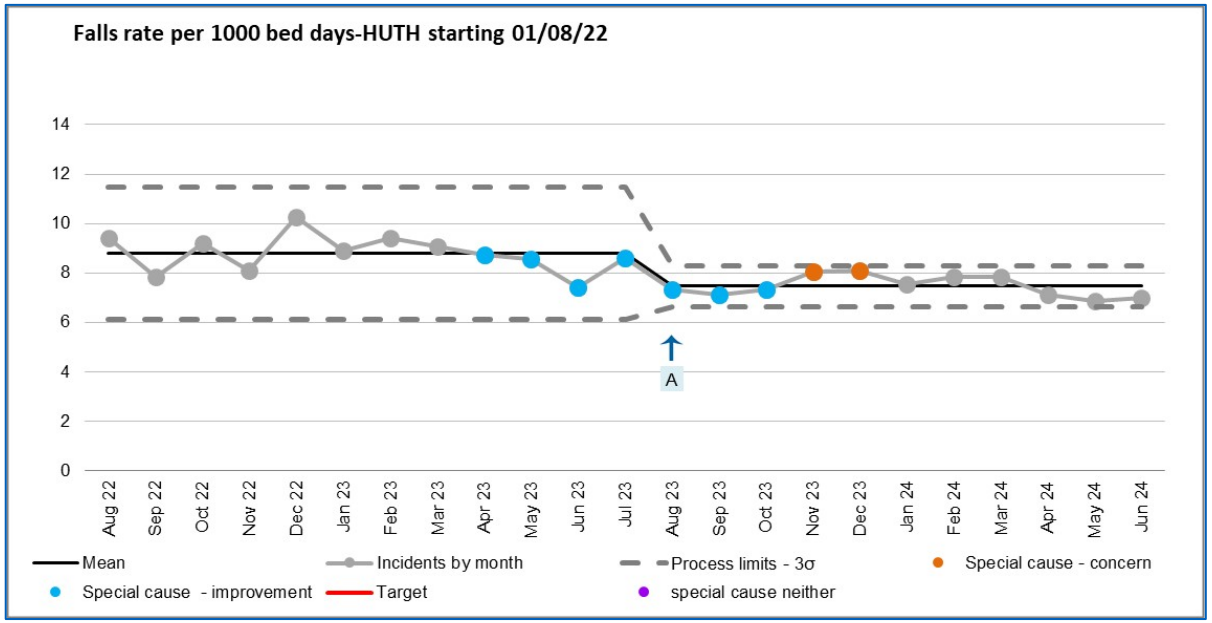
- The 12-month rolling HSMR is 94.77, slightly reduced from 96.64 in February 2024. The data has not changed since last month, because of an issue with missing the APC SUS submission due to Lorenzo implementation, but Information Services state that they have resubmitted the data now and when the data refresh is made to the national dataset, CHKS will be able to report after February 2024. This is impacting on inpatient data, (this is a SUS, and HES process) This should be resolved in the next month.

NHS Humber Health Partnership Mortality Improvement Group –The Group mortality meetings have been unified as one meeting from August 2024

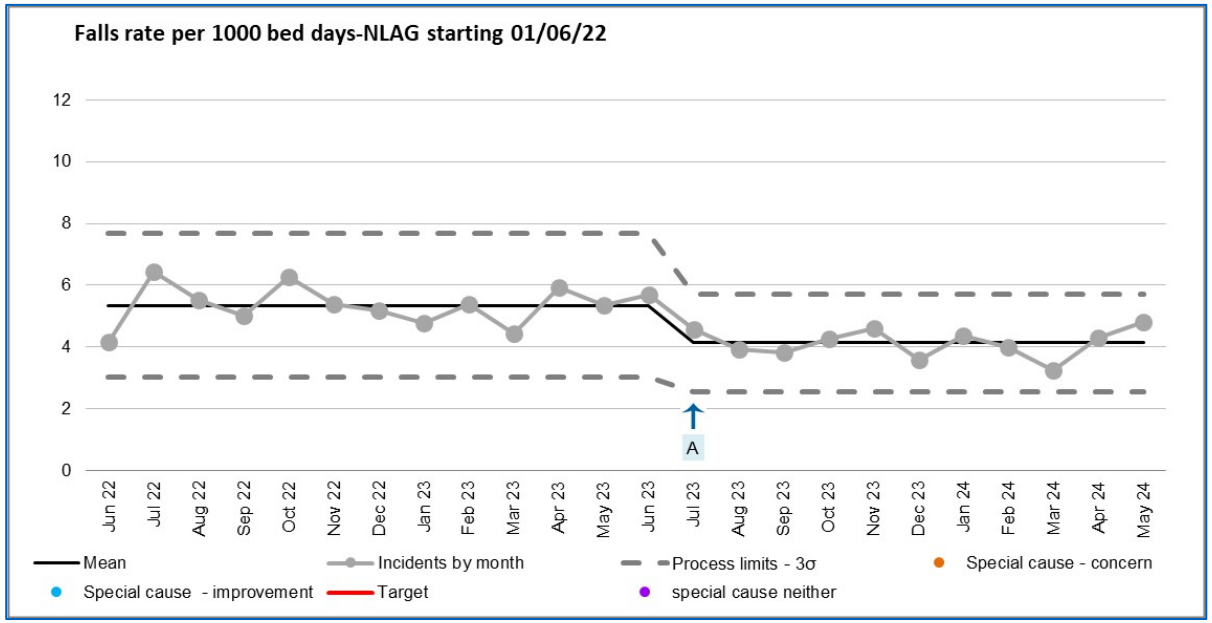
Falls

Humber Health Partnership

HUTH



NLAG

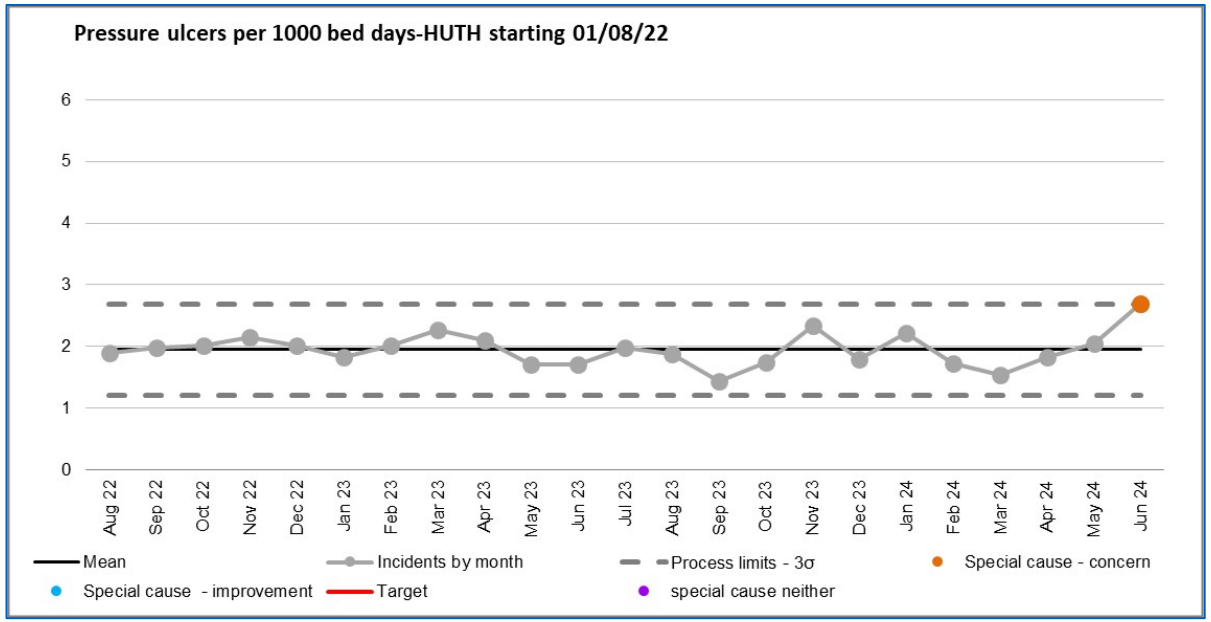


- HUTH – Falls rate shows a reduction from April 23, with revised control limits from August 2023, now showing as normal variation for the recent period.
  - Falls team review patients who have fallen on a daily basis to support interventions to prevent further falls, use of Swarm huddles in place.
- NLAG Falls rate data has not been updated since last month, However, the SPC chart has been updated with revised control limits from July 2023. The rates remain within expected variation.
  - Repeated fall cases are reviewed by Matrons and Swarm huddles are used to review care provision. A strategic action plan is in place.

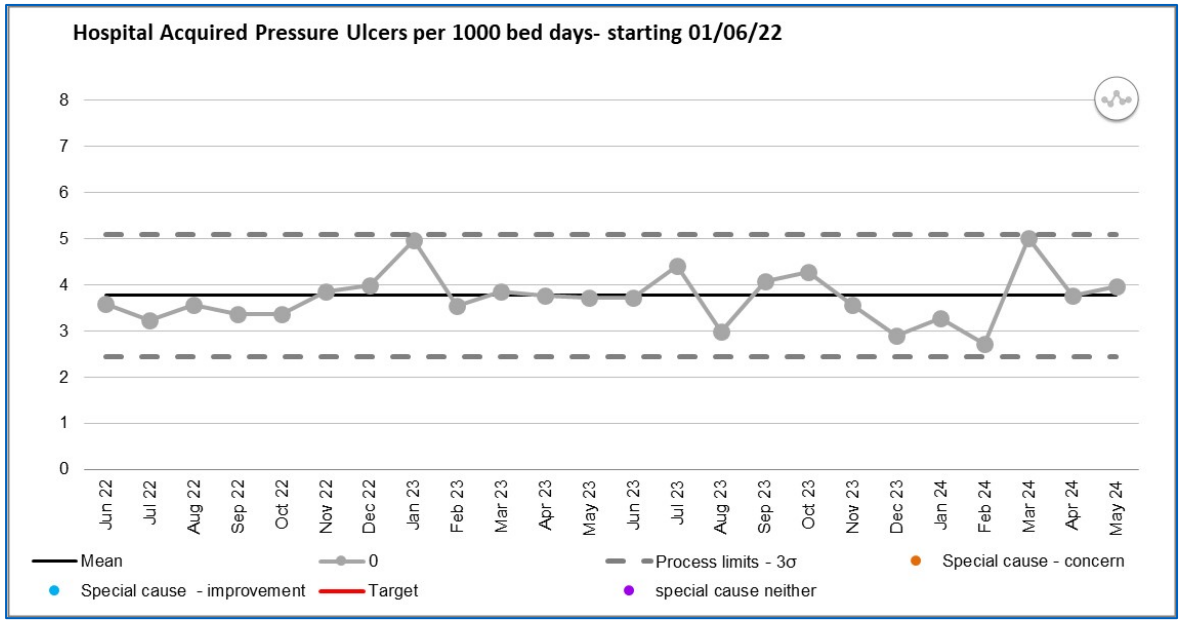
Pressure Ulcers

Humber Health Partnership

HUTH



NLAG

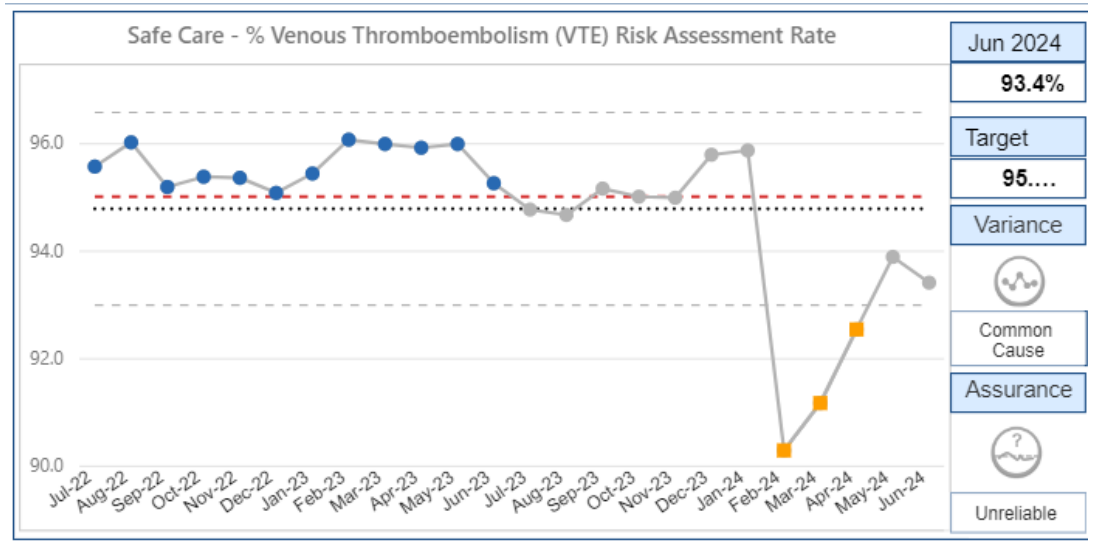


- HUTH – The rate shows a significant increase for June, exceeding the upper control limit. This is due to an increase in reporting of category 1 pressure ulcers, as the Trust has targeted improving the completeness of reporting.
- NLAG – Pressure ulcer rate data has not been updated since the last report on PowerBI reports. The data shown remains within the normal variation range.

VTE risk assessment rate

Humber Health Partnership

NLAG VTE July 2022-June 2023



NLAG

- Following a period of inability to report following the Lorenzo implementation, the data is now available. There has been a reduction in compliance, which is subject to validation and verification of the mapping of data capture. Work is ongoing with the CMIO, with ePMA being the sole source of VTE assessment rather than WebV and picked up through a coding function.

HUTH

- BI developing a VTE SPC chart monthly currently only captured quarterly.
- There has now been three months of improved compliance since April 2024, above 95% for the last 3 months.
- VTE support provided by QI team, improvement actions. Pilot wards agreed, working with digital nurse team some areas of non compliance to target further improvement

HUTH VTE Performance 1/6/2023 – 25/7/2024

VTE Performance

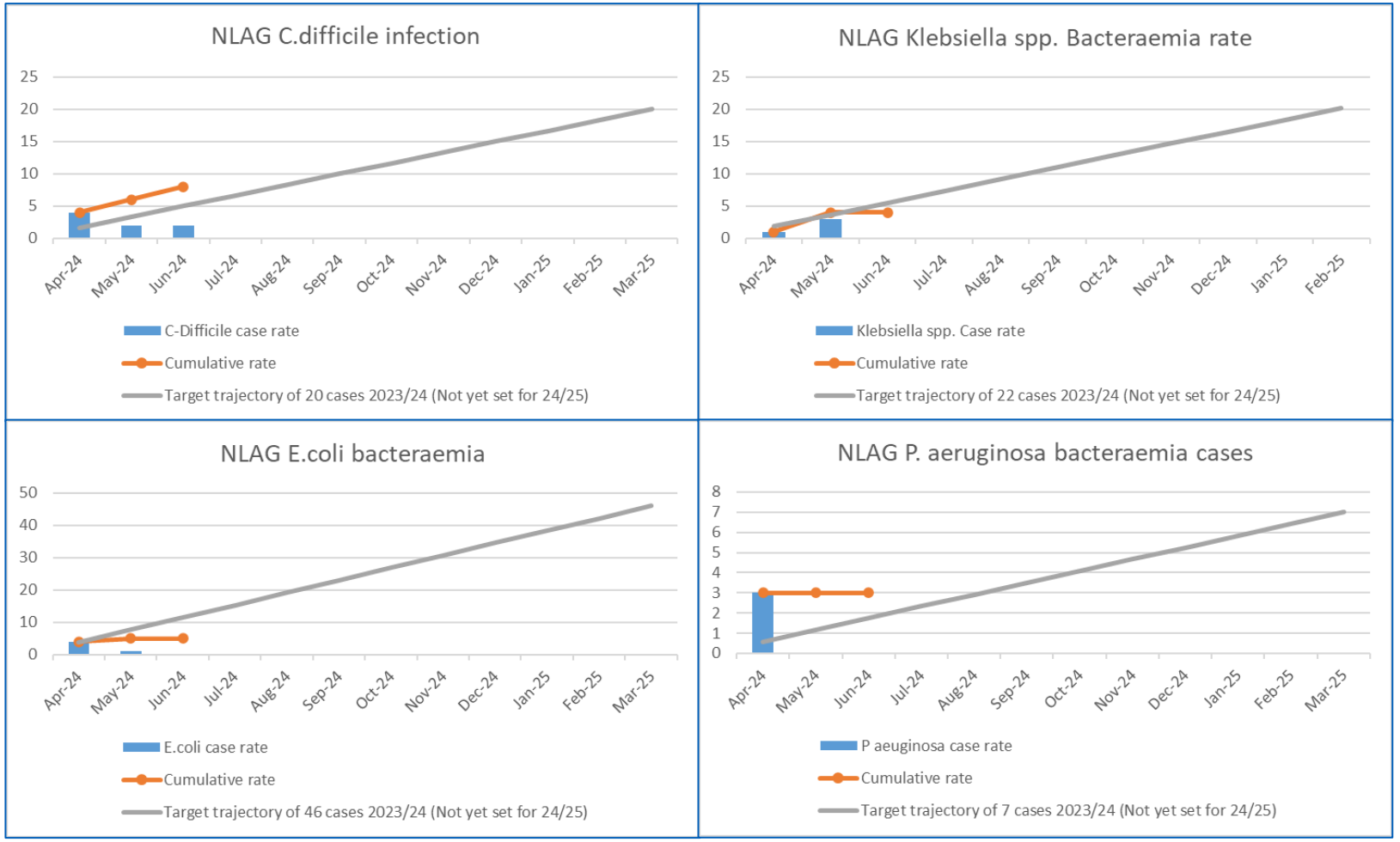
Summary by Admit Ward - Trust national target - 95%

* For untested patients that are part of an approved cohort which is reliant on a procedure being clinically coded, these will not show as tested/cohorted until the clinical coding has been completed for the admission. Upon completion of coding, were that code is part of an agreed cohort, the admission will display as 'Tested / cohorted'

		Possibly at risk		At risk				At Risk			Overall Performance %			
Admit Month	Assessed & Prescribed	Assessed Only	Proph Indicated & Prescribed	Proph Indicated But Not Prescribed	Cohorted	Prescribed Only	Proph Not Indicated But Prescribed	Untested *	Total Admissions		Assessed Only Performance	Prescribed Performance	Assessed and Cohorted Performance	Assessed, Cohorted and Prescribing Performance
Jul-2023	510	833	2126	565	7433	343	43	746	12599		78.09%	58.50%	91.02%	94.08%
Aug-2023	558	800	1980	482	7647	352	88	728	12635		76.58%	59.70%	90.76%	94.24%
Sep-2023	498	899	1912	689	7451	346	63	822	12680		76.46%	53.91%	90.29%	93.52%
Oct-2023	529	926	2163	737	7876	298	79	772	13380		79.12%	55.76%	91.41%	94.23%
Nov-2023	412	890	2186	665	8201	266	68	716	13404		79.82%	56.35%	92.17%	94.66%
Dec-2023	518	901	1961	573	7047	286	55	739	12080		78.54%	56.03%	91.06%	93.88%
Jan-2024	524	1010	2257	622	8309	274	67	769	13832		79.90%	56.53%	91.98%	94.44%
Feb-2024	468	882	2181	577	7993	227	52	708	13088		80.63%	57.47%	92.46%	94.59%
Mar-2024	516	968	2175	729	7619	252	75	730	13064		80.59%	55.43%	91.91%	94.41%
Apr-2024	539	928	2351	676	8179	241	76	564	13554		83.61%	59.67%	93.50%	95.84%
May-2024	517	917	2248	658	8204	230	77	562	13413		83.32%	58.97%	93.52%	95.81%
Jun-2024	526	923	2146	624	7852	201	53	565	12890		83.74%	58.08%	93.65%	95.62%
Jul-2024	404	784	1913	589	6473	206	54	519	10942		82.57%	57.66%	92.88%	95.26%
Total	6519	11661	27599	8186	100284	3522	850	8940	167561		80.21%	57.21%	92.06%	94.66%

Infection Control - NLAG

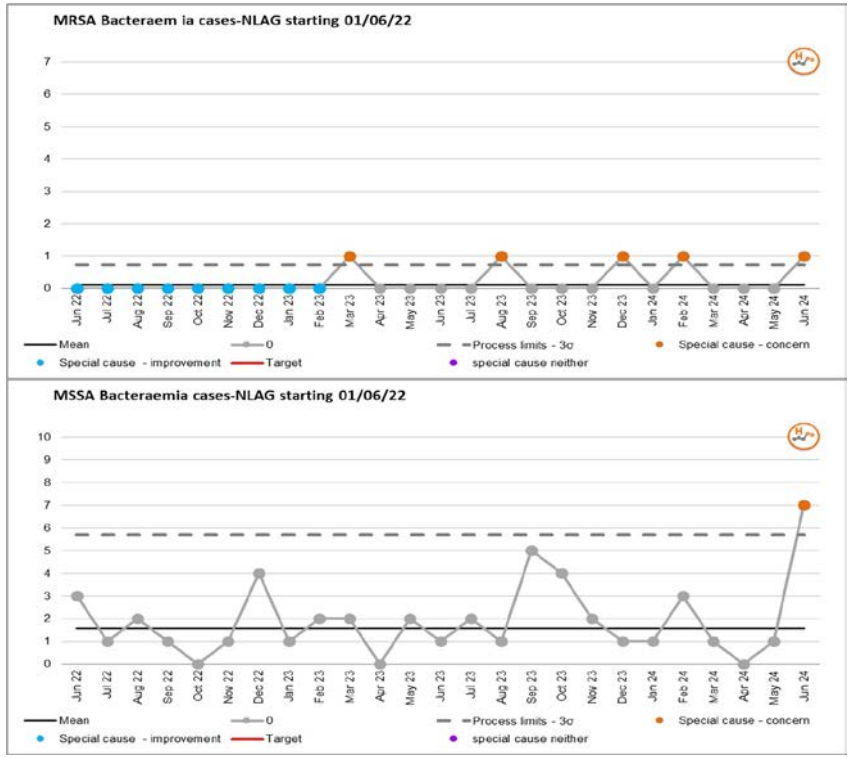
Humber Health Partnership



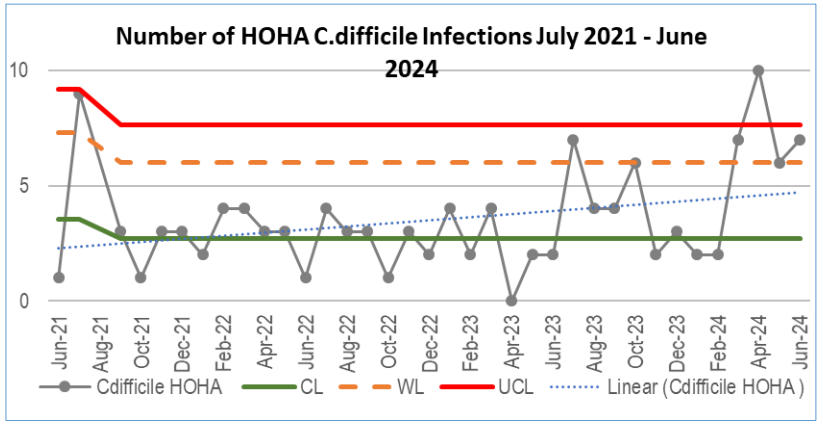
PHE have not set trajectories for any organisations yet. 2023/24 target trajectories are shown until the new targets are set.

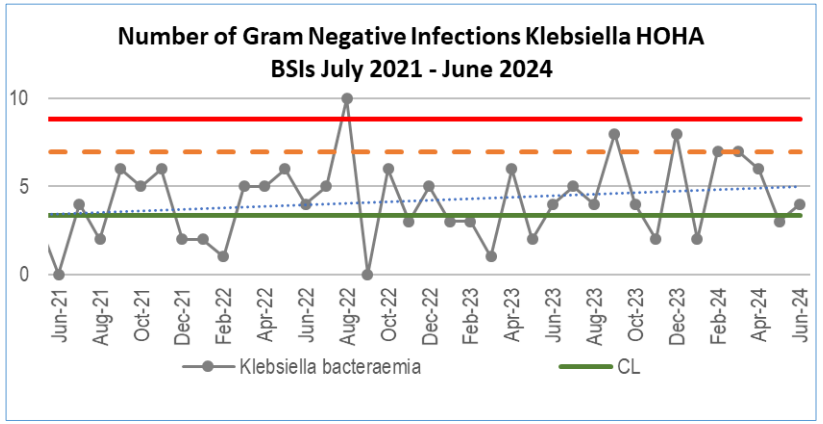
NLAG

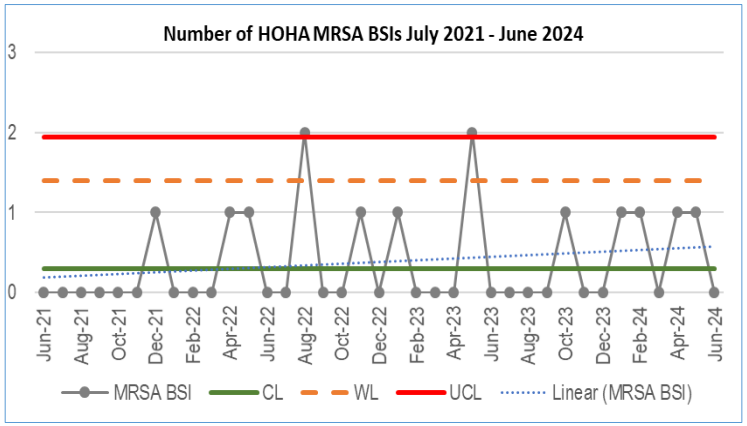
- C.Difficile – over the target trajectory.
- E.Coli – under the target trajectory.
- Klebsiella – under the target trajectory.
- P.Aeruginosa – over the target trajectory
- MRSA bacteriaemia – zero target and 1 case in 2024/25
- MSSA – no target, but an increased rate in June 2024

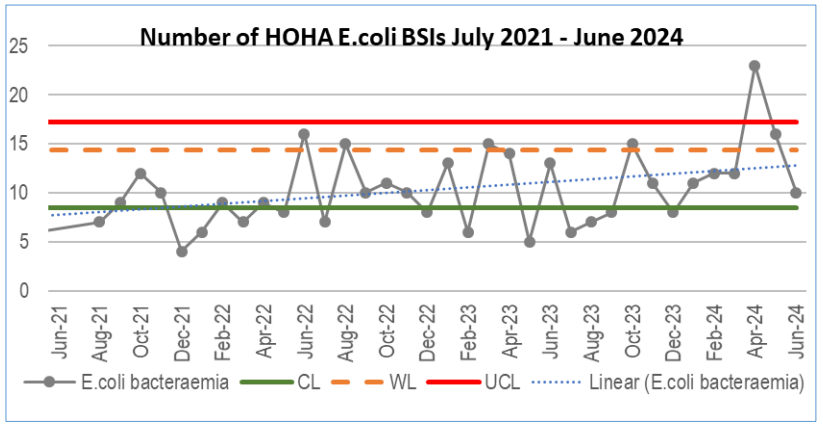


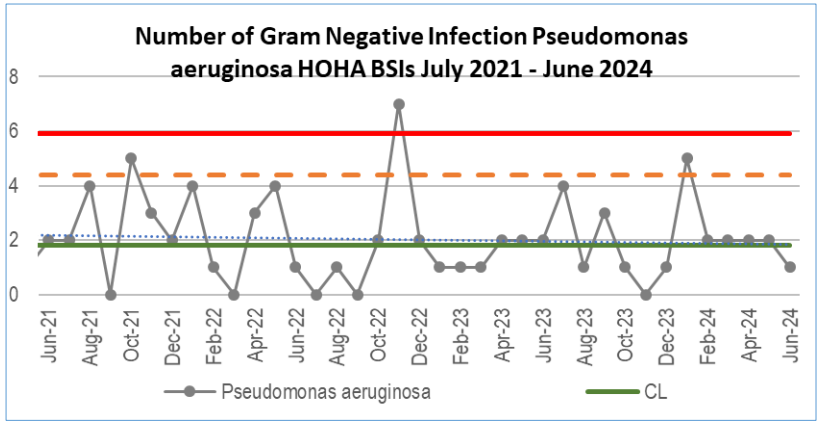
Infection Control - HUTH

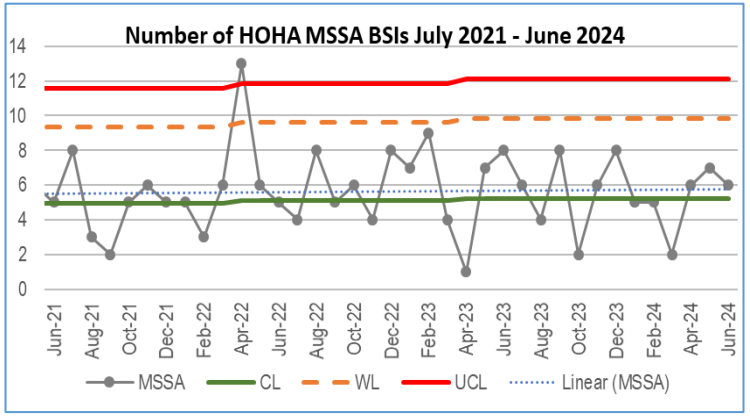












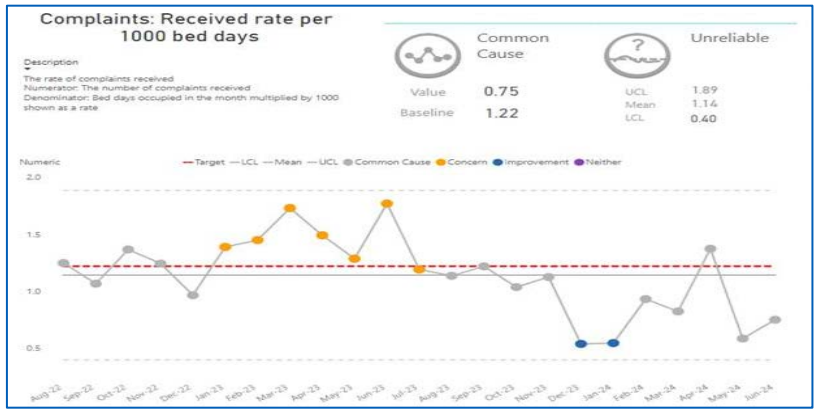
PHE have not set trajectories for any organisations yet. 2023/24 target trajectories shown until the new targets are set.

- C.Difficile – over the target trajectory
- E.Coli – over the target trajectory
- Klebsiella – under the target trajectory
- P.Aeruginosa – Under the target trajectory
- MRSA bacteriaemia – zero target 0 cases in June
- MSSA – no target 6 cases in June 2024

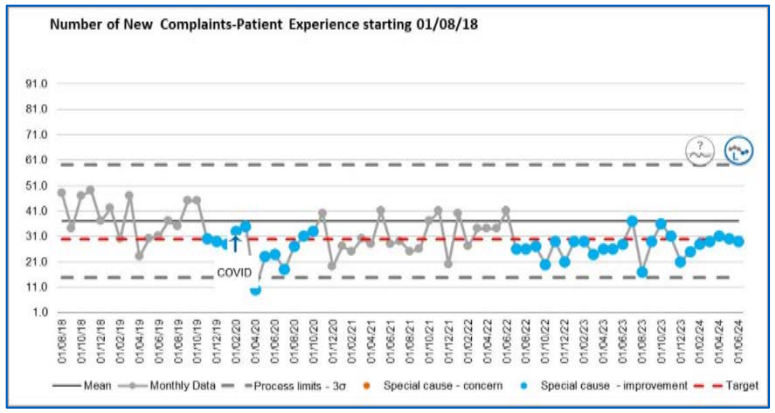
Complaints

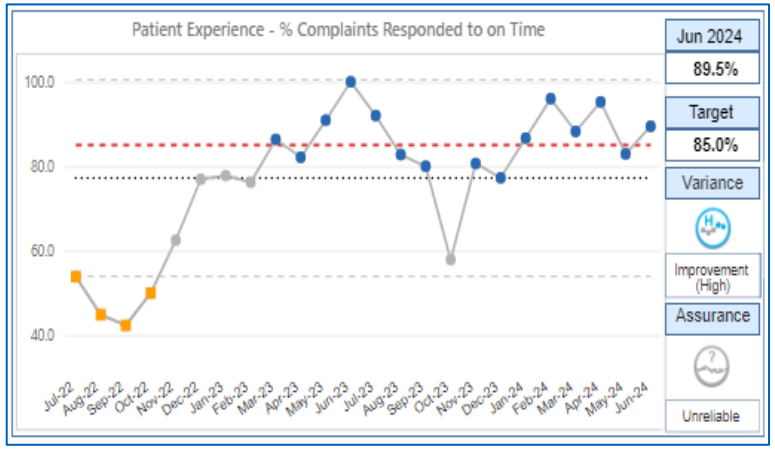
Humber Health Partnership

HUTH



NLAG





The BI team are in the process of converting complaints data to produce the complaints per 1,000 bed days.

NLAG - There is an anomaly with the for bed days accuracy. The run rate on complaints remains within normal variation for the recent period on the 2nd chart shown to capture actual numbers.

Completion performance remains better than target at 89.6%

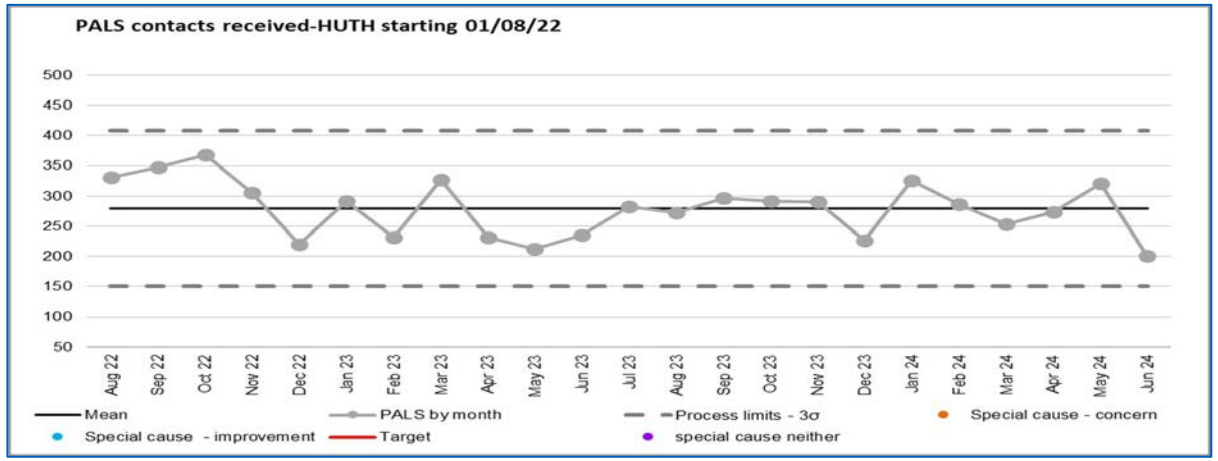
HUTH -The complaints in May and June 2024 have reduced, in line with a reducing trend from the complaints peak experienced in Qtr 1 and Qtr 2 of 2023/24. There was previously an increase in April 2024 but not indicative of a trend.

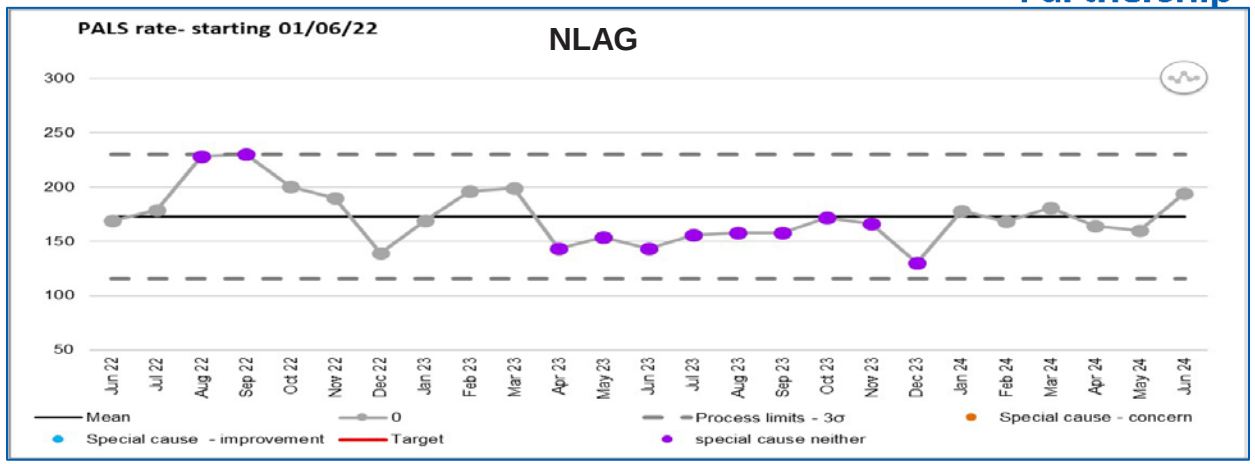
The second chart shows complaints closed within 60 working at the end of June 2024 of 50%. Whilst there is an average of 57 days to close, the Trust has focused on closing backlog long standing cases in April and May 2024 accounting for dip.

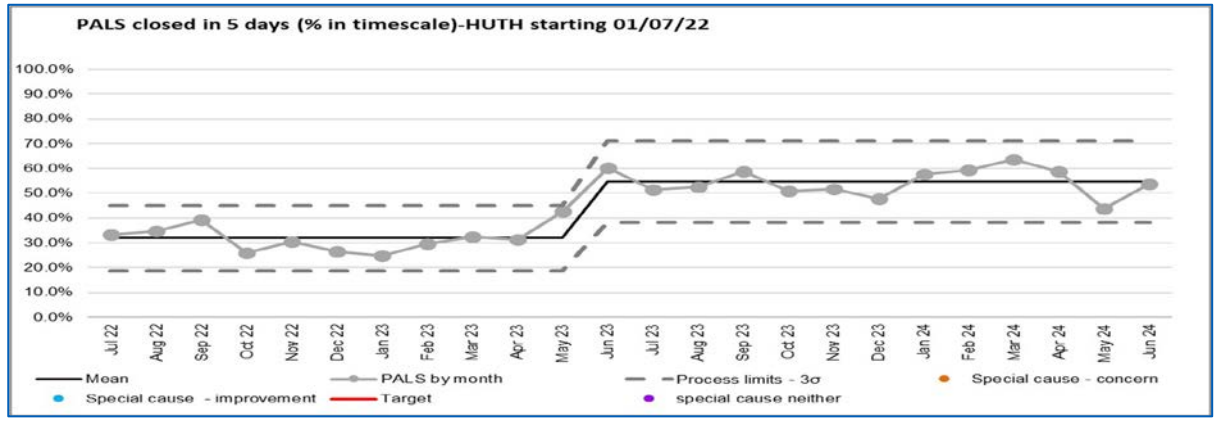
GROUP - As at 30 June 2024, the Group had 49 complaints that had not been responded to within 60 days which is a key area for targeted improvement being monitored by Site Executive teams.

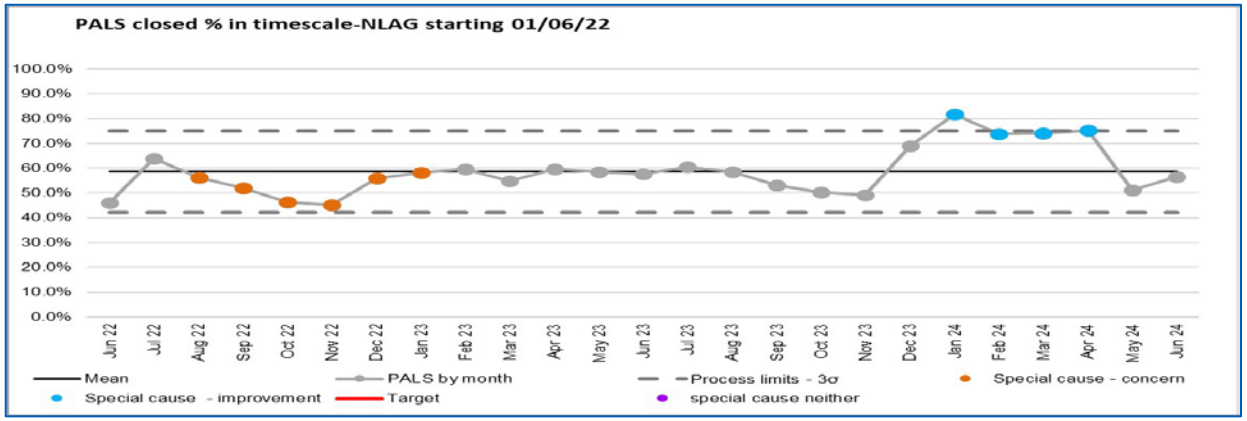
PALS

NHS
Humber Health
Partnership









HUTH - There is normal variation in the rate of PALS contacts for the most recent period. The timeliness of completion has improved from Jun 2023 and now is static follow the control limit revision. the National Blood Inquiry drove an increase in PALs primarily on the North Bank (by c.50 PALS – 20% of monthly activity).

NLAG - There is normal variation in the rate of PALS contacts for the most recent period. The completion rate had improved but has returned to normal variation in May and June 2024.

Patient Experience – Friends and Family Test

Humber Health Partnership

Key Performance Indicator	HUTH	Period	Target		SPC Last 12 Months	Centile
Friends & Family A&E Score		Apr 24	85%	70%		9
Friends & Family Birth Score		Apr 24	95%	92%		38
Friends & Family Inpatient Score		Apr 24	95.00%	91.7%		15
Friends & Family Outpatient Score		Apr 24	95%	94%		33

Key Performance Indicator	NLAG	Period	Target		SPC Last 12 Months	Centile
Friends & Family A&E Score		Apr 24	85%	84%		73
Friends & Family Birth Score		Apr 24	95%	100%		100
Friends & Family Community Score		Apr 24	95%	97%		55
Friends & Family Inpatient Score		Apr 24	95.00%	97.7%		86
Friends & Family Outpatient Score		Apr 24	95%	93%		20

NLAG generally performs in top quartile and in line with or above regional performance. There is some tentative improvement in HUTH FFT performance in Inpatient areas (up 5% since March 2023 CQC inspection report). Despite achieving a 100% FFT Birth score for 7 months from November 2023 to March 2024, there was a reduction to 92% in April 2024. Inpatient data has been made available to new care group structures for targeted improvement.
In June 2024, HUTH A&E Inpatient FFT had improved to 72%, Inpatient 92.4%, Outpatient 94.7%.

Group People Directorate

Workforce Integrated Performance Report

Indicator	Key variations in the data	What actions are in place to mitigate?
Vacancy	Consultant Vacancy Rate: The **Groups** current consultant vacancy rate is 91.2 FTE (10.8%) **NLAG's** current consultant vacancy rate is 62.4FTE (20%) **HUTH's** current consultant vacancy rate is 28.8 FTE (5.4%) The main vacancy rate is within the Acute and Emergency Medicine across Operations South with a consultant vacancy rate of 38.2FTE (36.9%) Band 5 Registered Nursing Vacancy Rate: The Groups current Band 5 Registered Nurse vacancy rate is 129.9FTE (4.2%) **NLAG's** current Band 5 registered nursing vacancy rate is 112FTE (9.4%) **HUTH's** current Band 5 registered nursing vacancy rate is 18 FTE (0.9%) The main vacancy rate is within the Acute and Emergency Medicine across Operations South with a band 5 nursing registered vacancy rate of 56.6 FTE (12.2%)	Focussed oversight of Consultant recruitment driving continuous activity and increasing numbers of active adverts and sourcing. Recruitable vacancy position has decreased by 2.9 WTE, and there are 25 Consultants in the pipeline appointed expected to start within 3 months. Group-wide approach to Consultant AAC process has been agreed by executive cabinet. This will now be translated to a group wide AAC policy for agreement with LNC. Development of a medical workforce strategy is currently taking place and is expected to be completed in August 2024 following release of Group strategy to ensure alignment. 251 NQNs appointed across the group to commence between September and November 2024 expected to fill all recruitable registered nurse vacancies. International recruitment of registered nurses stood down.
Agency	**HUTH** One individual remains off framework who is being utilised in Haematology due to the service demand.	**NLAG** Off Framework agency usage ceased on 28th June 2024 General agency usage has plateaued at a reasonable level when compared with vacancies.

		Work continues with the reduced Nursing and Midwifery Preferred Supplier List (PSL) of agencies with the aim of reducing rates of all shifts to NHSE cap by October 24. **HUTH**- Nursing and Midwifery agency reduced and currently only being utilised in the Emergency Department. In conjunction with NLAG colleagues a PSL for the Group is being developed with consistent rates planned for October 2024. Plans in place for Off Framework Agency Medic in Haematology to cease in September 2024. **Group** For further ease of access the already established data sets, which include SPC's and historic and future agency and Bank bookings, to be transferred to Power BI dashboard to enable triangulation with establishment, vacancy and absence data.
Turnover	**NLAG's** current turnover rate is 10.3%, marginally above the target of 10%. This represents a 0.2% increase from the previous reporting period. **HUTH's** current turnover rate is 9.2%, which is still within the target of 10%. This position has stayed the same as the previous reporting period. As a **Group** the turnover rate is 9.7% **Group** - Both Trusts have a disproportionate number of employees leaving within their first year of service, within Additional Clinical Services, Estates and Ancillary, and Admin and Clerical staff groups in comparison with the wider workforce.	Turnover remains stable and on a steadily reducing trajectory. We continue to focus on reducing avoidable resignations. Exit questionnaires consistently highlight work life balance and career progression as key concerns. On the 1st August the group intends to launch a employee assistance programme along side a wider employee wellbeing scheme. This will provide all employees with access to health and wellbeing tools and support such as counselling, legal advice, financial support and a host of online self help materials. This will also provide managers access to trained individuals to discuss any employee related concerns with emotional wellbeing in mind.

		Improving the quality of data from exit questionnaires is crucial for gaining valuable insights into why employees leave and how the Group can improve. A new Group Exit Questionnaire is currently being developed, in line with the ICB retention programme. This will be launched October 2024. Engagement scores from the staff survey are now routinely shared with all managers at a group level and are monitored at site performance meetings. The new Group induction process will go live from August 2024 and will focus on the first 100 days –Getting it right first time to welcome new starters into the Group and giving them all the tools and training they need to be able to do their job. People Promise Managers are now commencing delivery of the People promise project and will focus on Flexible working, health and wellbeing, a voice that counts and we are always learning, with a specific focus on talent management and PADR .
Consultant and SAS Job Plans	**Group**- Absence of a Job Planning Framework and Policy across the Group to support system reconfiguration and reporting.	**Group-** Establishment of Working Group to include Deputy Chief Medical Officer, Associate Director-Strategic Medical Workforce and Director of People Services to develop Job Planning Framework and Policy across the Group to support system reconfiguration and reporting.
Sickness	The current sickness rate at **NLAG** is 5.1%, above target of 4%, reflecting an increase of 0.2% from the last reporting period. The current sickness rate at **HUTH** is 4%, which is at target, reflecting a 0.1% increase from the last reporting period.	The HR team continues to support managers in taking ownership of absence management by providing additional training. Leadership development initiatives help managers adopt compassionate leadership practices and recognize early signs and triggers of mental health issues.

	The data indicates that stress, anxiety, and depression are the leading causes of absence in both Trusts. As a **Group** the sickness rate is 4.4%, 0.4% above target of 4%	**Group –** . The new Group HR Workforce Power BI solution has been launched, providing managers with comprehensive insights into their workforce at the group level. However, there are still discrepancies in sickness triggers. We plan to align the sickness policy across the Group in conjunction with the broader HR policy suite.
Appraisals	As a Group, both trusts are not meeting the target for Appraisals of 85% **NLAG's** Appraisals rate is 80.9% against a target of 85%. Only Estates and Ancillary staff groups are meeting the target, while all other staff groups are not. **HUTH**, there are no staff groups meeting the 85% target.	Monthly meetings with managers will continue, using available reports (e.g., HR Dashboard) to identify staff who have not completed their appraisals. Regular communications will be sent to staff who are not in compliance. For **HUTH**, data is sent from HEY 24/7 through the HR team to address non-compliance areas. **NLAG's** ESR team is actively communicating with managers regarding non-compliant PADRs and continues to support them by myths, providing gentle reminders, and offering education. Additionally, the new Group HR Workforce Power BI Solution has been launched, giving managers comprehensive oversight of their entire workforce in one centralized location.
Medical Appraisals	**Group**- Two separate systems used within the Group for Revalidation, Appraisal and 360 feedback (NLaG- L2P and HUTH- Premier IT).	**Group-** Exercise currently being undertaken to procure Revalidation, Appraisal and 360 feedback systems as HUTHs contract ends in Dec 2024 and NLaGs contract ends October 2026. The aim is to procure one standardised system going forward as and when contracts come to their natural end.
Core Mandatory Training	**NLAG** reports that overall core required learning is 90.4%, with all competencies reporting above the target except: **Fire Safety** which was 80.5% at the time of reporting. There has been a steady improvement in compliance for this core area since January 2024	Due to the high volume of staff that required face to face fire training in **NLAG** following Covid, there have been resource challenges at SGH whilst Gray's Room (lecture theatre) has been out of use. This is now fully operational, and the team have 1990 spaces available for face-to-face training up to the end of September (329 are currently required to achieve 85%). L&D continue to send directed emails to those staff out of

	when it was introduced into the corporate induction. Non-attendance remains a concern for this classroom-based provision with 337 DNAs (Did Not Attend) during Q1 of 2024-25 (approximately 20% of enrolments to the planned sessions during the same period). **Information Governance and Data Security** – currently 86.9% with a target of 95% **HUTH** reports compliancy on most of the Core Required Learning topics with an overall compliancy of 83.8% at the time of reporting. The target for topics is currently 85% except Information Governance which is targeted at 95%. The following topics are where **HUTH** are underachieving: Information Governance – 87.2% Resuscitation – 77.6% Safeguarding Adults Level 3 – 81.3% Moving and Handling (Clinical) – 81.2% **NLAG** reports that all staff groups, except Medical and Dental, achieved the 85% target at the time of reporting. Medical and Dental report 69.5%, with only Equality, Diversity and Human Rights achieving the target compliance.	compliance and HRBPs continue to work directly with care groups. A pressure across in **HUTH** is mirrored from the south in that there are a large number of DNA's at sessions. There are ample sessions being organised for the workforce but the DNA's are preventing the training sessions from being optimised for capacity. The loss of the Castle Hill training centre put pressure on classroom-based teaching and sessions were cancelled or moved to other venues with lower capacity. This will be improved when the new Centre for Learning and Innovation opens at the end of the calendar year. The new style Trust Induction being launched in August 2024, will also help with improving compliancy as new starters will commence in post, having completed their required learning online. The Group Required Learning Steering Group has now been approved with the first meeting booked for 22.7.24. From this group, a working group will be established to review the required learning for the Medical and Dental staff group across the Humber Health Partnership, considering the time resource for completion of training and its impact on patient care and safety.
Roles Specific Training	**NLAG's** role specific compliance is 79.5% at the time of reporting, 5.5% below target. Operations North reports 80.8%, with 603 competencies	HRBPs will continue to work directly with care groups to address non-compliance, supported by Learning and Development through on-going analysis and targeted emails where required.

	required to achieve target. Operations South reports 78.8% compliance, with 1707 competencies required to achieve target. **HUTH** role specific learning is currently under compliance at 76.4%. A major factor contributing to this is that aged topics are included which are no longer required such as COVID related training. This will need to be analysed as part of the new Required Learning Steering Group. **NLAG** reports that non-attendance to classroom-based provision remains a concern with 1662 DNAs (Did Not Attend) across all provision during Q1 of 2024-25, approximately 13% of all enrolments. Within **NLAG**, Staff Group Medical and Dental report a role specific compliance of 58.6%, with only one competency achieving the 85% target. Within **NLAG**, resuscitation training remains a concern with an overall compliance of 66% (all levels combined) at the time of reporting. The highest volumes of staff require Level 2 Adult Basic Life Support which, is 68.4% compliant at the time of reporting, with 605 competencies required to achieve target.	DNA rates to be included in Power BI so that managers can access detail of non-attendance in their areas. Learning and Development will continue to liaise with HRBPs regarding levels of non-attendance monthly. The Group Required Learning Steering Group has now been approved with the first meeting booked for 22.7.24. From this group, a working group will be established to review the required learning for Medical and Dental staff group, considering the time resource for completion of training and its impact on patient care and safety. The Group will also perform a Training Needs Analysis to identify those role specific topics that may need removing or amending to reflect current practices. This will hopefully reduce the burden on the workforce. Following a period of vacancies, the NLAG Resus Training Team is now fully established, and the Head of Learning South has provided support for curriculum planning to ensure sufficient places are offered (at level 2 and 3) to meet demand across the Trust for annual updates. Current trajectories affirm that Level 2 (Adult and Paediatric) and Level 3 (Adult) provision will achieve 85% by end of March 2025. Level 3 (Paediatric) will achieve 85% by the end of December 2024.
Recruitment KPI's	**NLAG -** Decreased activity in number of conditional offers issues caused by delays in approval process reducing number of adverts	**NLAG** - Approval process now up to date and number of active vacancies back to normal levels, will see number of conditional offers increasing

Group Workforce Establishment Trend

	HUTH												
	Mar -24	Apr-24	May-24	Jun-24	Jul-24	Aug -24	Sep -24	Oct-24	Nov -24	Dec-24	Jan-25	Feb -25	Mar-25
Establishment WTE	9003.5	8787.8	8877.6	8924.9									
Variance		215.7	89.8	47.3									
Vacancy WTE	228.5	74.6	186.6	229.5									
Variance		153.9	112	42.9									
Staff In Post WTE	8775.0	8713.2	8691.0	8695.4									
Variance		61.8	22.2	4.4									
Headcount	10748.0	10762.0	10722.0	10716									
Variance		14	40	6									
Starters	59.87	58.58	40.21	66.55									
Leavers	100.54	77.13	55.49	56.73									
	NLAG												
Establishment WTE	7035.9	7036.0	7051.9	7074.3									
Variance		0.1	15.9	22.4									
Vacancy WTE	540.7	561.6	536.2	551.5									
Variance		20.9	25.4	15.3									
Staff In Post WTE	6495.3	6474.4	6515.7	6522.8									
Variance		20.9	41.3	7.1									
Headcount	8587.0	8589.0	8659.0	8606									
Variance		2	70	53									
Starters	78.88	30.16	37.68	40.76									
Leavers	66.38	38.76	42.4	50.65									

Red = Decrease

HUTH Substantive and Temporary Staffing by Health Group

	HUTH							
	Substantive Workforce				Temporary Workforce			
Health Group/Directorate	Establishment WTE	Staff in Post WTE	Vacancies WTE	Vacancy Rate %	Agency WTE	Bank WTE	Adjusted Vacancies WTE	Adjusted Vacancy Rate %
Cancer Network	28.4	33.5	-5.1	-18.0	0.0	0.0	-5.1	-18.0
Cardiovascular	396.4	385.1	11.2	2.8	1.0	5.0	5.2	1.3
Digestive Diseases	411.4	416.8	-5.3	-1.3	0.0	12.0	-17.3	-4.2
Head & Neck	374.3	344.7	29.6	7.9	2.0	3.0	24.6	6.6
Major Trauma Network	51.6	41.2	10.4	20.2	0.0	1.0	9.4	18.2
Patient Services	762.1	762.0	0.0	0.0	0.0	14.0	-14.0	-1.8
Specialist Cancer and Support Services	1374.7	1307.1	67.6	4.9	1.0	24.0	42.6	3.1
Chief Delivery Officer	35.5	30.4	5.1	14.3	0.0	0.0	5.1	14.3
Theatres, Anaesthetics and Critical Care	1066.5	1077.2	-10.6	-1.0	7.0	1.0	-18.6	-1.7
Acute and Emergency Medicine	505.3	476.9	28.4	5.6	10.0	23.0	-4.6	-0.9
Community, Frailty & Therapy	747.2	696.3	50.9	6.8	1.0	17.0	32.9	4.4
Family Services	742.0	733.5	8.5	1.2	3.0	9.0	-3.5	-0.5
Neuroscience	270.1	265.2	4.9	1.8	2.0	6.0	-3.1	-1.1
Pathology Network Group	61.0	52.5	8.5	14.0	0.0	0.0	8.5	14.0
Site Management & Discharge Teams	52.6	48.8	3.8	7.2	0.0	0.0	3.8	7.2
Specialist Medicine	351.4	345.9	5.5	1.6	1.0	14.0	-9.5	-2.7
Specialist Surgery	406.0	403.6	2.4	0.6	1.0	12.0	-10.6	-2.6
Corporate	773.0	801.6	-28.6	-3.7	0.0	0.0	-28.6	-3.7
Estates, Facilities and Development	515.4	473.1	42.3	8.2	0.0	2.0	40.3	7.8
Trust Total	**8924.9**	**8695.4**	**229.5**	**2.6**	**29.0**	**143.0**	**57.5**	**0.6**

NLAG Substantive and Temporary Staffing by Health Group

	NLAG							
	Substantive Workforce				Temporary Workforce			
Health Group/Directorate	Establishment WTE	Staff in Post WTE	Vacancies WTE	Vacancy Rate %	Agency WTE	Bank WTE	Adjusted Vacancies WTE	Adjusted Vacancy Rate %
Cancer Network	61.9	56.9	5.0	8.0	0.0	0.0	5.0	8.0
Cardiovascular	114.2	102.8	11.4	10.0	1.0	5.0	5.4	4.7
Digestive Diseases	382.3	356.7	25.7	6.7	2.0	20.0	3.7	1.0
Head & Neck	120.5	113.3	7.2	5.9	6.0	7.0	-5.8	-4.9
Major Trauma Network	78.2	76.7	1.5	1.9	0.0	3.0	-1.5	-1.9
Patient Services	582.0	548.2	33.8	5.8	0.0	25.0	8.8	1.5
Specialist Cancer and Support Services	485.2	428.8	56.4	11.6	7.0	10.0	39.4	8.1
Chief Delivery Officer	22.6	20.5	2.1	9.3	0.0	0.0	2.1	9.3
Theatres, Anaesthetics and Critical Care	535.5	487.3	48.3	9.0	11.0	26.0	11.3	2.1
Acute and Emergency Medicine	876.1	769.8	106.3	12.1	36.0	96.0	-25.7	-2.9
Community, Frailty & Therapy	868.5	841.3	27.2	3.1	10.0	45.0	-27.8	-3.2
Family Services	669.3	624.9	44.4	6.6	9.0	47.0	-11.7	-1.7
Neuroscience	122.3	109.9	12.4	10.2	2.0	11.0	-0.6	-0.5
Pathology Network Group	416.3	376.3	40.1	9.6	1.0	16.0	23.1	5.5
Site Management & Discharge Teams	52.9	49.7	3.1	5.9	0.0	4.0	-0.9	-1.6
Specialist Medicine	291.7	264.2	27.5	9.4	6.0	26.0	-4.5	-1.5
Specialist Surgery	194.5	178.0	16.4	8.4	8.0	14.0	-5.6	-2.9
Corporate	592.0	564.9	27.1	4.6	1.0	6.0	20.1	3.4
Estates, Facilities and Development	608.5	552.7	55.8	9.2	0.0	57.0	-1.2	-0.2
Trust Total	**7074.4**	**6522.9**	**551.7**	**7.8**	**100.0**	**418.0**	**33.5**	**0.5**

HUTH Substantive and Temporary Staffing by Staff Group

	HUTH							
	Substantive Workforce				Temporary Workforce			
Staff Group	Establishment WTE	Staff in Post WTE	Vacancies WTE	Vacancy Rate %	Agency WTE	Bank WTE	Adjusted Vacancies WTE	Adjusted Vacancy Rate %
Additional Clinical Services	1484.1	1385.6	98.5	6.6	0.0	74.0	24.5	1.6
Add Prof Scientific and Technical	262.3	264.9	-2.6	-1.0	0.0	5.0	-7.6	-2.9
Administrative and Clerical Staff	1739.4	1722.6	16.9	1.0	0.0	14.0	2.9	0.2
Allied Health Professionals	693.1	647.7	45.4	6.6	1.0	0.0	44.4	6.4
Estates and Ancillary	619.9	570.9	49.1	7.9	0.0	2.0	47.1	7.6
Healthcare Scientists	165.1	163.4	1.6	1.0	1.0	0.0	0.6	0.4
Medical & Dental - Consultant	536.7	508.9	27.8	5.2	18.0	0.0	9.8	1.8
Medical & Dental - SAS	75.5	62.1	13.4	17.7	0.0	0.0	13.4	17.7
Medical & Dental – Trainee Grades	726.8	731.7	-4.9	-0.7	6.0	15.0	-25.9	-3.6
Nursing and Midwifery Registered	2581.0	2595.7	-14.6	-0.6	3.0	34.0	-51.6	-2.0
Students	41.0	42.0	-1.0	-2.4	0.0	0.0	-1.0	-2.4
Trust Total	**8924.9**	**8695.4**	**229.5**	**2.6**	**29.0**	**143.0**	**57.5**	**0.6**

NLAG Substantive and Temporary Staffing by Staff Group

	NLAG							
	Substantive Workforce				Temporary Workforce			
Staff Group	**Establishment WTE**	**Staff in Post WTE**	**Vacancies WTE**	**Vacancy Rate %**	**Agency WTE**	**Bank WTE**	**Adjusted Vacancies WTE**	**Adjusted Vacancy Rate %**
Additional Clinical Services	1482.3	1375.1	107.2	7.2	1.0	123.0	-16.8	-1.1
Add Prof Scientific and Technical	101.1	86.3	14.9	14.7	1.0	2.0	11.9	11.8
Administrative and Clerical Staff	1369.3	1295.1	74.2	5.4	1.0	37.0	36.2	2.6
Allied Health Professionals	463.7	451.5	12.2	2.6	8.0	7.0	-2.8	-0.6
Estates and Ancillary	587.7	538.5	49.3	8.4	0.0	69.0	-19.7	-3.4
Healthcare Scientists	218.2	197.4	20.8	9.5	1.0	5.0	14.8	6.8
Medical & Dental - Consultant	315.2	253.3	61.9	19.6	23.0	12.0	26.9	8.5
Medical & Dental - SAS	217.2	198.4	18.8	8.7	20.0	12.0	-13.2	-6.1
Medical & Dental – Trainee Grades	318.7	296.1	22.7	7.1	10.0	31.0	-18.4	-5.8
Nursing and Midwifery Registered	1994.5	1824.6	169.9	8.5	35.0	120.0	14.9	0.7
Trust Total	**7067.9**	**6516.3**	**551.9**	**7.8**	**100.0**	**418.0**	**33.5**	**0.5**

Group Consultant Recruitment Activity

	WTE
Current Vacancies	87.8
Royal College Approval	5
Recruitment plan in development within Care Group	2
Authorisation	2
Advertising	9
Shortlisting	2
Interview	4
Activity still to be established	10.2
Not to be recruited to - vacancies less than 0.2 WTE	1.8
Appointed awaiting start	25
Recruitable Vacancy Position	61

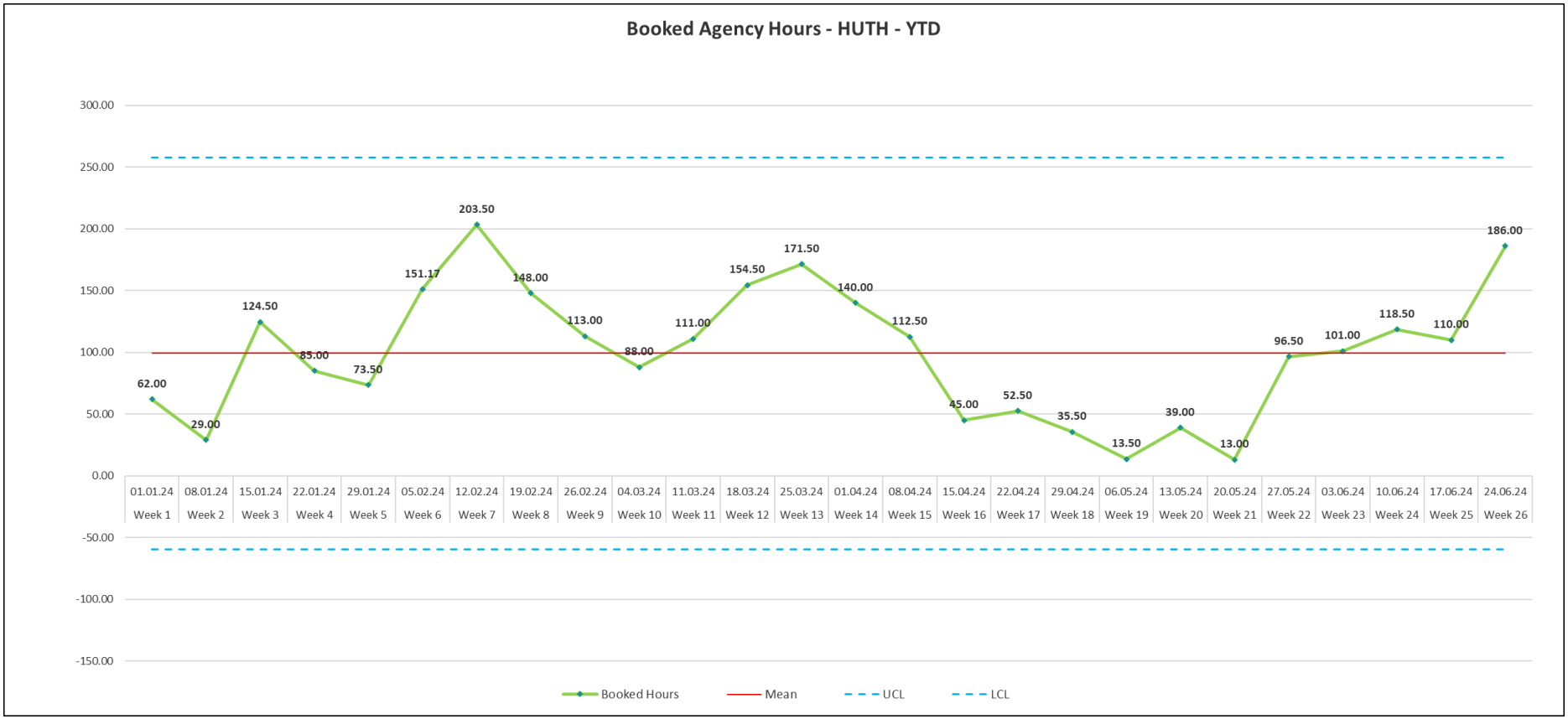
- Activity still to be established has been reduced from 14.9 last month to 10.2 currently.
- Recruitable vacancy position has been reduced from 63.9 WTE last month to 61 WTE currently.
- Appointed awaiting start is still 25 WTE – however a number of previous appointments have started, and new appointments made. All routes are being explored to commence starts as soon as possible.
- Recruitment plans are being developed. Consultant recruitment plans in development within Care Groups last month was 12 and is now 2 currently.
- Number of live adverts is increasing, although a snapshot at one point in the month the reported position last month was 5 live adverts, compared to 9 currently.
- Targeted recruitment campaigns are underway, currently focussed upon Acute and Emergency Medicine with some activity around smaller vacancy areas including T&O and Breast Surgery
- A Group-wide approach to AACs has been approved by Executive Cabinet and is currently being worked up into a policy.
- Broad marketing campaigns to establish the Group as an employer of choice.
- Continuous driving of activity against all recruitable Consultant vacancies
- A complete library of all Job Descriptions for recruitable vacancies has been established, including expiry dates or Royal College approval to facilitate effective planning with Care Groups

Group Substantive and Temporary Staffing Comments

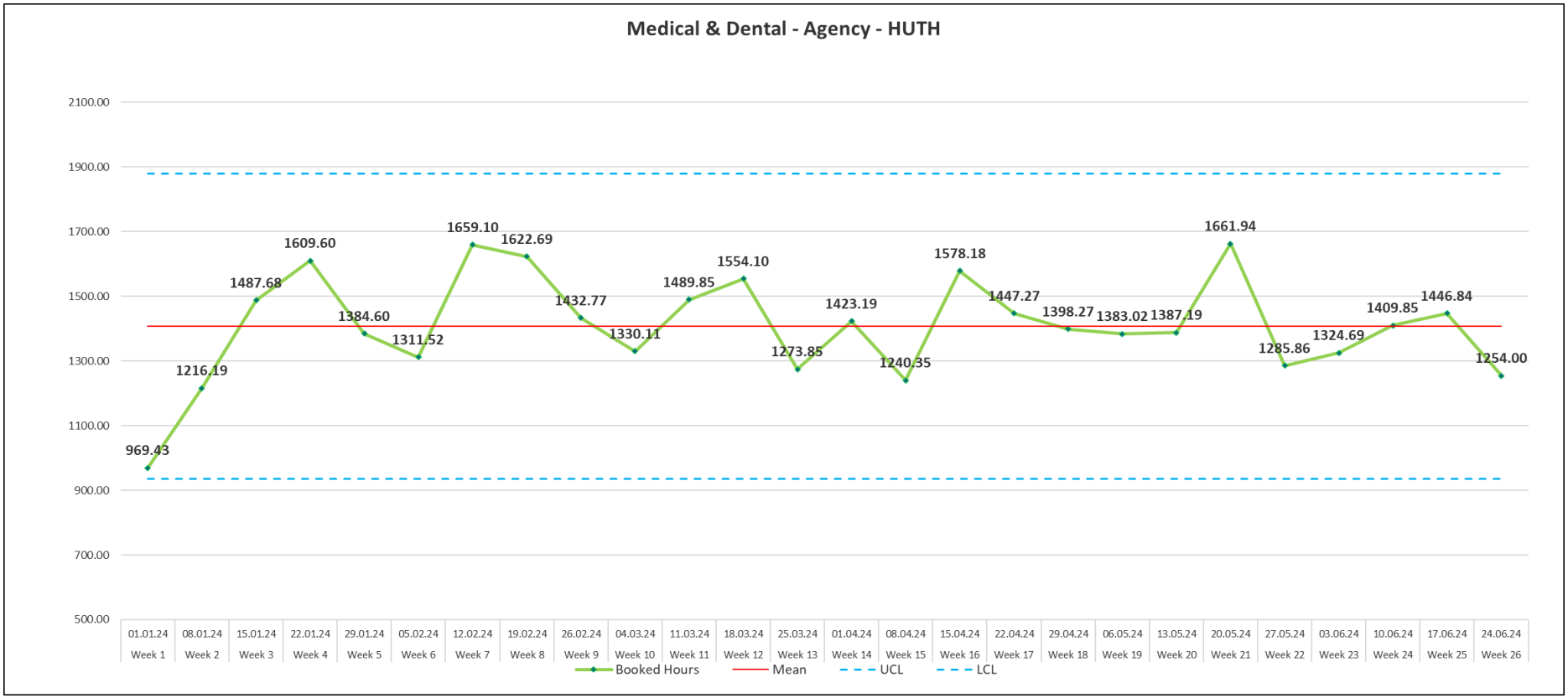
HUTH	NLAG
The Trust has 8,695.4 WTE substantive staff and in June 24 resourced 172 WTE temporary staff	The Trust has 6522.9 WTE substantive staff and in June 24 resourced 518 WTE temporary staff
The vacancy rate for the Trust is 229.5 WTE (2.6%) and this reduces to 57.5 WTE (0.6%) when adjusted for temporary staffing usage, taken this above establishment.	The vacancy rate for the Trust is 551.7 WTE (7.8%) and this reduces to 33.5 WTE (0.5%) when adjusted for temporary staffing usage, taken this is above establishment.
Nursing and Midwifery Registered Staff are over establishment by 14.6 WTE (- 0.6%)	Nursing and Midwifery Registered Staff have 169.9 WTE vacancies (8.5%)
Medical and Dental Consultants have 27.8 WTE (5.2%) vacancies. This reduces to 9.8 WTE (1.8%) when adjusted for temporary staffing usage.	Medical and Dental Consultants have 61.9 WTE (19.6%) vacancies. This reduces to 26.9 WTE (8.5%) when adjusted for temporary staffing usage.

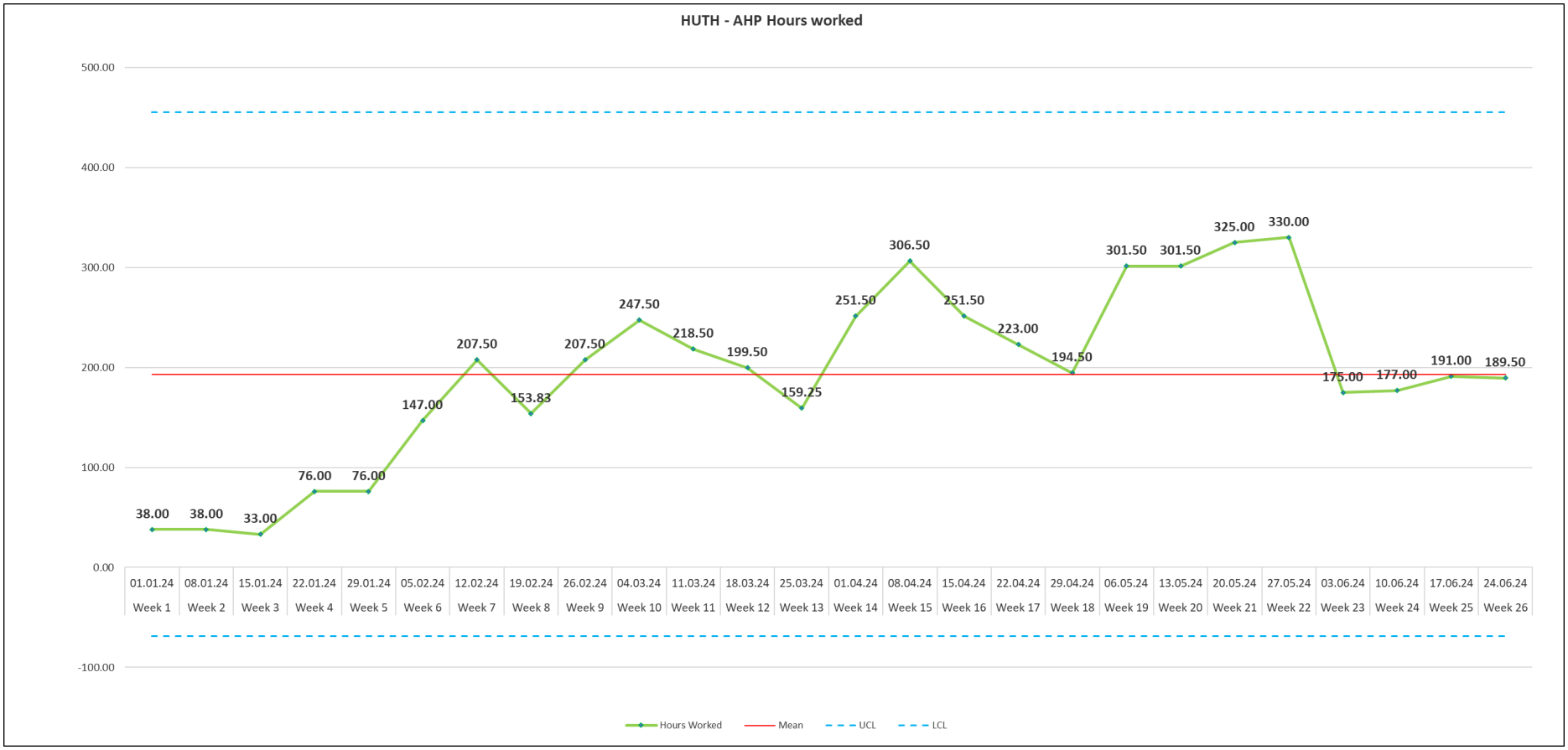
HUTH Agency Hours Worked Performance

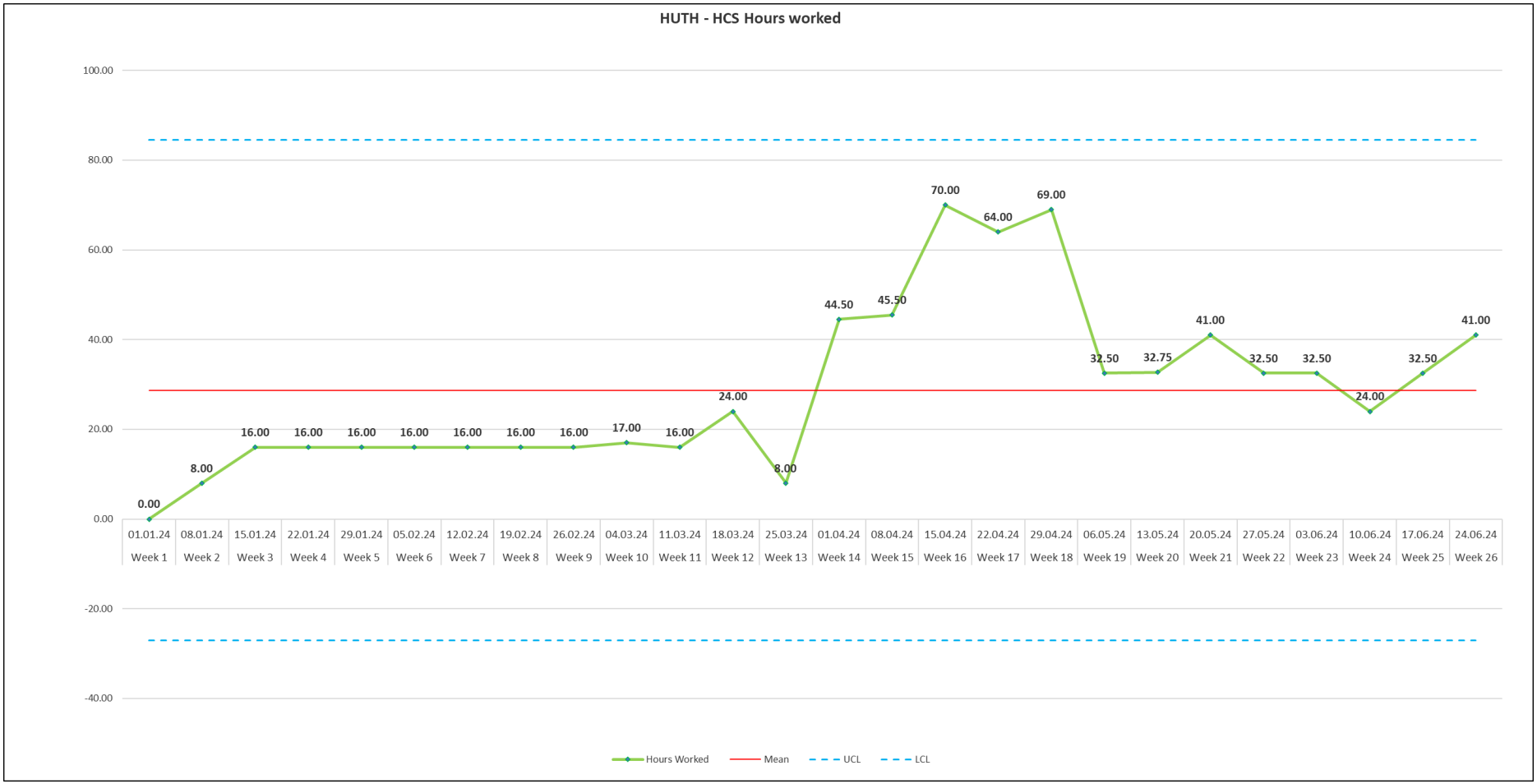
Nursing



Medical and Dental

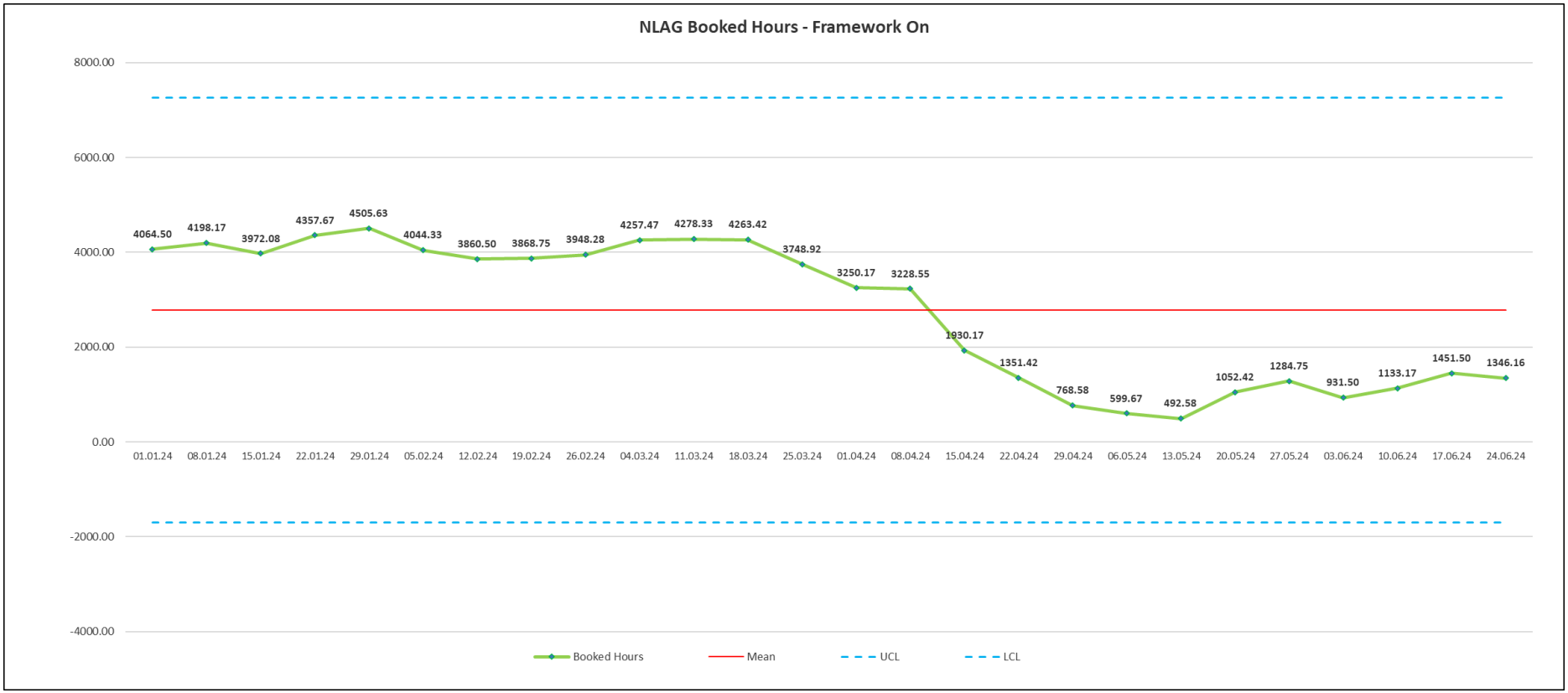


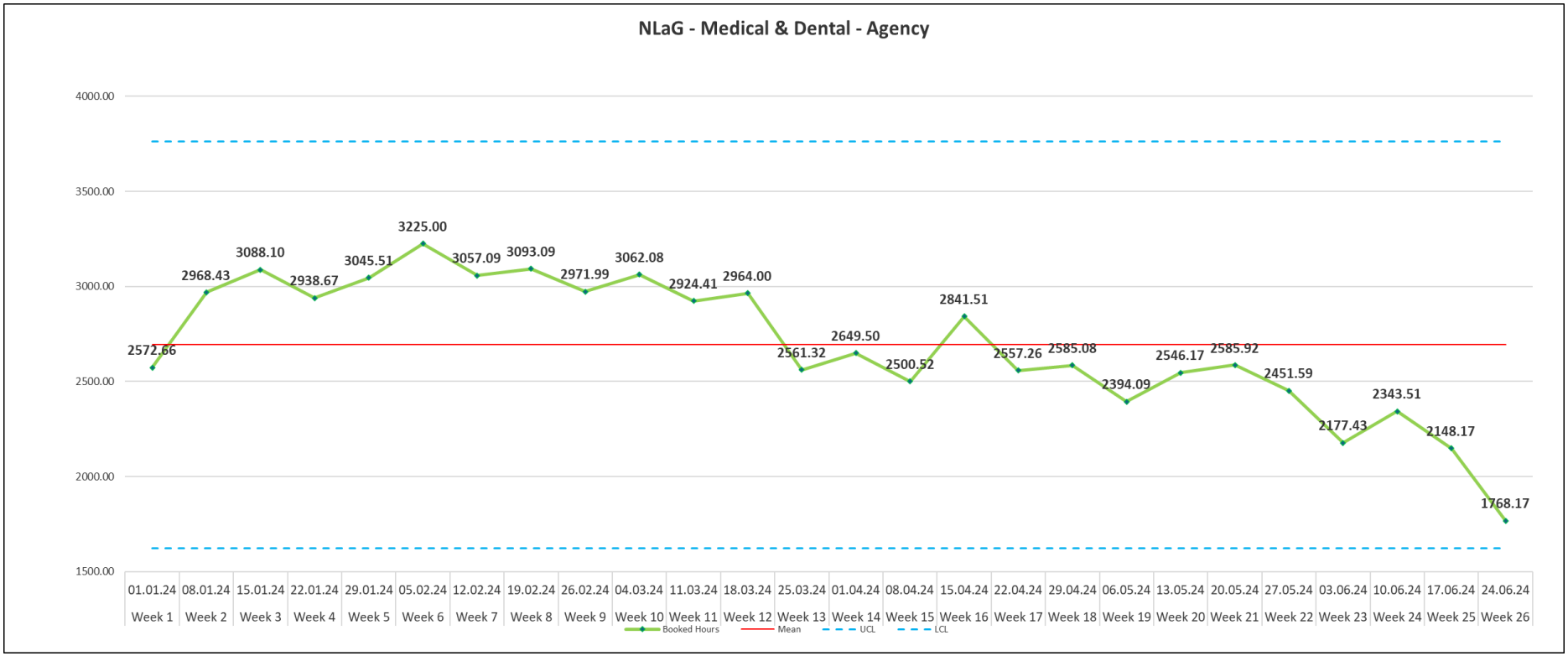

HUTH - AHP Hours worked
500.00
400.00
300.00
200.00
100.00
0.00
-100.00
38.00
38.00
33.00
76.00
76.00
147.00
207.50
153.83
207.50
247.50
218.50
199.50
159.25
251.50
306.50
251.50
223.00
194.50
301.50
301.50
325.00
330.00
175.00
177.00
191.00
189.50
01.01.24 Week 1
08.01.24 Week 2
15.01.24 Week 3
22.01.24 Week 4
29.01.24 Week 5
05.02.24 Week 6
12.02.24 Week 7
19.02.24 Week 8
26.02.24 Week 9
04.03.24 Week 10
11.03.24 Week 11
18.03.24 Week 12
25.03.24 Week 13
01.04.24 Week 14
08.04.24 Week 15
15.04.24 Week 16
22.04.24 Week 17
29.04.24 Week 18
06.05.24 Week 19
13.05.24 Week 20
20.05.24 Week 21
27.05.24 Week 22
03.06.24 Week 23
10.06.24 Week 24
17.06.24 Week 25
24.06.24 Week 26
Hours Worked
Mean
UCL
LCL


HUTH - HCS Hours worked
100.00
80.00
60.00
40.00
20.00
0.00
-20.00
-40.00
0.00
8.00
16.00
16.00
16.00
16.00
16.00
16.00
16.00
17.00
16.00
24.00
8.00
44.50
45.50
70.00
64.00
69.00
32.50
32.75
41.00
32.50
32.50
24.00
32.50
41.00
01.01.24 Week 1
08.01.24 Week 2
15.01.24 Week 3
22.01.24 Week 4
29.01.24 Week 5
05.02.24 Week 6
12.02.24 Week 7
19.02.24 Week 8
26.02.24 Week 9
04.03.24 Week 10
11.03.24 Week 11
18.03.24 Week 12
25.03.24 Week 13
01.04.24 Week 14
08.04.24 Week 15
15.04.24 Week 16
22.04.24 Week 17
29.04.24 Week 18
06.05.24 Week 19
13.05.24 Week 20
20.05.24 Week 21
27.05.24 Week 22
03.06.24 Week 23
10.06.24 Week 24
17.06.24 Week 25
24.06.24 Week 26
Hours Worked
Mean
UCL
LCL

NLAG Agency Hours Worked Performance

Nursing

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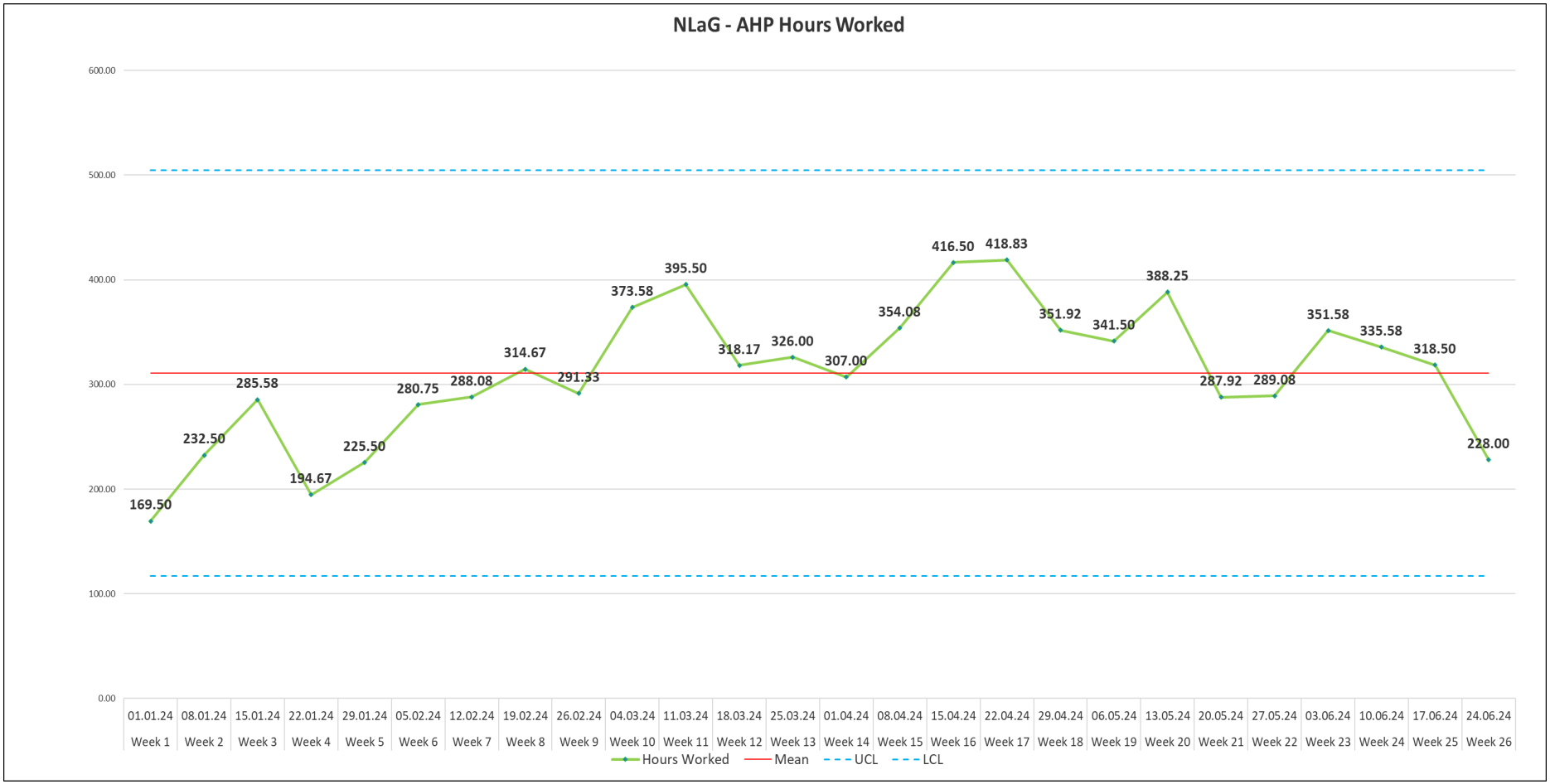
01.01.24 Week 1
08.01.24 Week 2
15.01.24 Week 3
22.01.24 Week 4
29.01.24 Week 5
05.02.24 Week 6
12.02.24 Week 7
19.02.24 Week 8
26.02.24 Week 9
04.03.24 Week 10
11.03.24 Week 11
18.03.24 Week 12
25.03.24 Week 13
01.04.24 Week 14
08.04.24 Week 15
15.04.24 Week 16
22.04.24 Week 17
29.04.24 Week 18
06.05.24 Week 19
13.05.24 Week 20
20.05.24 Week 21
27.05.24 Week 22
03.06.24 Week 23
10.06.24 Week 24
17.06.24 Week 25
24.06.24 Week 26
Booked Hours
Mean
UCL
LCL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373.58
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318.17
326.00
307.00
354.08
416.50
418.83
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351.58
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318.50
228.00
01.01.24 Week 1
08.01.24 Week 2
15.01.24 Week 3
22.01.24 Week 4
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05.02.24 Week 6
12.02.24 Week 7
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20.05.24 Week 21
27.05.24 Week 22
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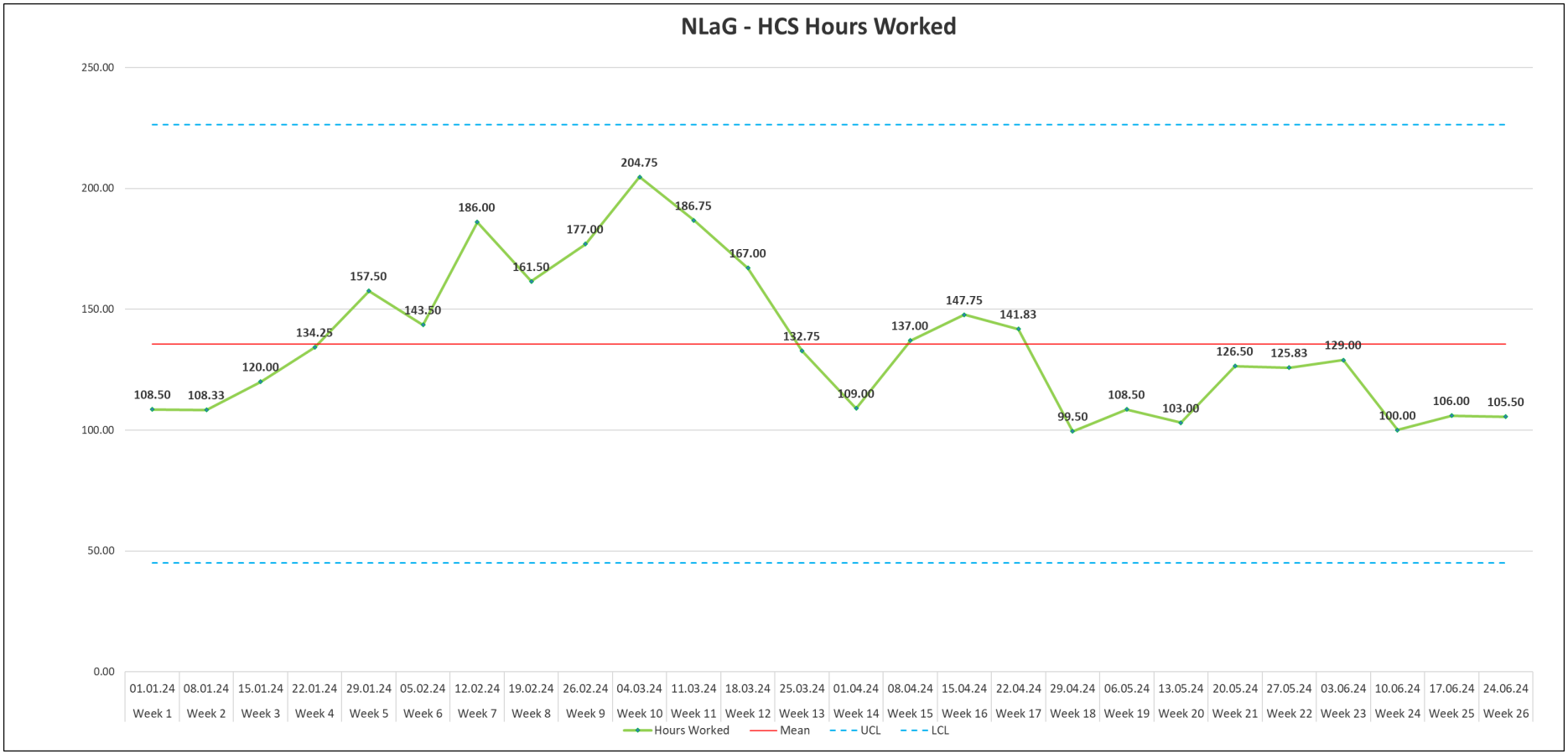
10.06.24 Week 24
17.06.24 Week 25
24.06.24 Week 26
Hours Worked
Mean
UCL
LCL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08.01.24 Week 2
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22.01.24 Week 4
29.01.24 Week 5
05.02.24 Week 6
12.02.24 Week 7
19.02.24 Week 8
26.02.24 Week 9
04.03.24 Week 10
11.03.24 Week 11
18.03.24 Week 12
25.03.24 Week 13
01.04.24 Week 14
08.04.24 Week 15
15.04.24 Week 16
22.04.24 Week 17
29.04.24 Week 18
06.05.24 Week 19
13.05.24 Week 20
20.05.24 Week 21
27.05.24 Week 22
03.06.24 Week 23
10.06.24 Week 24
17.06.24 Week 25
24.06.24 Week 26
Hours Worked
Mean
UCL
LCL

Group Turnover by Health Group

	% Turnover				
Health Group/Directorate	**Target**	**HUTH Rate %**	**Variance %**	**NLAG Rate %**	**Variance %**
Cancer Network	10	**14.8%**	4.8	**5.9%**	-4.1
Cardiovascular	10	**8.1%**	-1.9	**3.7%**	-6.3
Digestive Diseases	10	**8.1%**	-1.9	**7.8%**	-2.2
Head & Neck	10	**9.1%**	-0.9	**13.7%**	3.7
Major Trauma Network	10	**5.2%**	-4.8	**13.6%**	3.6
Patient Services	10	**12.1%**	2.1	**10.4%**	0.4
Specialist Cancer and Support Services	10	**8.4%**	-1.6	**9.6%**	-0.4
Chief Delivery Officer	10	**14.0%**	4.0	**21.0%**	11.0
Theatres, Anaesthetics and Critical Care	10	**7.9%**	-2.1	**9.8%**	-0.2
Acute and Emergency Medicine	10	**9.8%**	-0.2	**8.3%**	-1.7
Community, Frailty & Therapy	10	**11.1%**	1.1	**12.6%**	2.6
Family Services	10	**5.5%**	-4.5	**8.8%**	-1.2
Neuroscience	10	**5.2%**	-4.8	**11.7%**	1.7
Pathology Network Group	10	**17.5%**	7.5	**11.8%**	1.8
Site Management & Discharge Teams	10	**6.6%**	-3.4	**10.9%**	0.9
Specialist Medicine	10	**6.7%**	-3.3	**13.7%**	3.7
Specialist Surgery	10	**9.3%**	-0.7	**13.7%**	3.7
Corporate	10	**11.1%**	1.1	**10.4%**	0.4
Estates, Facilities and Development	10	**13.2%**	3.2	**9.4%**	-0.6
Total	10	**9.2%**	**-0.8**	**10.3%**	**0.3**

Group Turnover by Staff Group

	% Turnover				
Staff Group	**Target**	**HUTH Rate %**	**Variance %**	**NLAG Rate %**	**Variance %**
Additional Clinical Services	10	**13.8%**	3.8	**13.0%**	3.0
Add Prof Scientific and Technical	10	**5.8%**	-4.2	**9.2%**	-0.8
Administrative and Clerical Staff	10	**11.4%**	1.4	**10.7%**	0.7
Allied Health Professionals	10	**8.1%**	-1.9	**12.9%**	2.9
Estates and Ancillary	10	**11.3%**	1.3	**9.3%**	-0.7
Healthcare Scientists	10	**7.7%**	-2.3	**8.3%**	-1.7
Medical & Dental - Consultant	10	**3.7%**	-6.3	**4.4%**	-5.6
Medical & Dental - SAS	10	**11.1%**	1.1	**10.4%**	0.4
Nursing and Midwifery Registered	10	**6.6%**	-3.4	**8.4%**	-1.6
Trust Total	**10**	**9.2%**	**-0.8**	**10.3%**	**0.3**

Group Turnover – Tenure of Leavers by Health Group – Rolling 12 months.

		Tenure of Leavers HUTH			Tenure of Leavers NLAG		
Health Group	**Less than 1 Year % of leavers Target**	**Less than 1 Year WTE**	**More than 1 Year WTE**	**Less than 1 Year % of leavers**	**Less than 1 Year WTE**	**More than 1 Year WTE**	**Less than 1 Year % of leavers**
Cancer Network	15%	0.00	4.40	**0.0%**	0.00	2.00	**0.0%**
Cardiovascular	15%	4.00	20.90	**16.1%**	1.00	2.20	**31.5%**
Digestive Diseases	15%	5.60	23.50	**19.4%**	3.90	18.10	**17.9%**
Head & Neck	15%	6.60	20.50	**24.5%**	2.00	10.30	**16.3%**
Major Trauma Network	15%	0.00	2.10	**0.0%**	3.20	6.90	**32.2%**
Patient Services	15%	31.80	59.00	**35.1%**	9.30	38.70	**19.4%**
Specialist Cancer and Support Services	15%	21.00	77.00	**21.4%**	6.30	29.90	**17.3%**
Chief Delivery Officer	15%	1.00	4.60	**17.9%**	1.50	5.00	**22.9%**
Theatres, Anaesthetics and Critical Care	15%	20.20	73.50	**21.6%**	3.20	38.30	**7.6%**
Acute and Emergency Medicine	15%	12.80	24.30	**34.4%**	15.40	31.30	**33.0%**
Community, Frailty & Therapy	15%	19.00	50.80	**27.2%**	19.60	78.00	**20.1%**
Family Services	15%	4.90	30.20	**13.8%**	4.10	39.50	**9.3%**
Neuroscience	15%	3.20	8.00	**29.0%**	0.00	11.50	**0.0%**
Pathology Network Group	15%	2.60	5.30	**32.4%**	6.20	36.60	**14.5%**
Site Management & Discharge Teams	15%	0.00	2.90	**0.0%**	0.00	4.50	**0.0%**
Specialist Medicine	15%	2.80	16.20	**14.7%**	5.50	20.60	**21.3%**
Specialist Surgery	15%	2.00	28.40	**6.6%**	5.00	13.30	**27.3%**
Corporate	15%	16.40	61.80	**21.0%**	1.40	49.70	**2.7%**
Estates, Facilities and Development	15%	17.40	43.60	**28.6%**	6.60	45.80	**12.5%**
Trust Total	**15%**	**171.40**	**556.80**	**23.5%**	**94.20**	**482.20**	**16.4%**

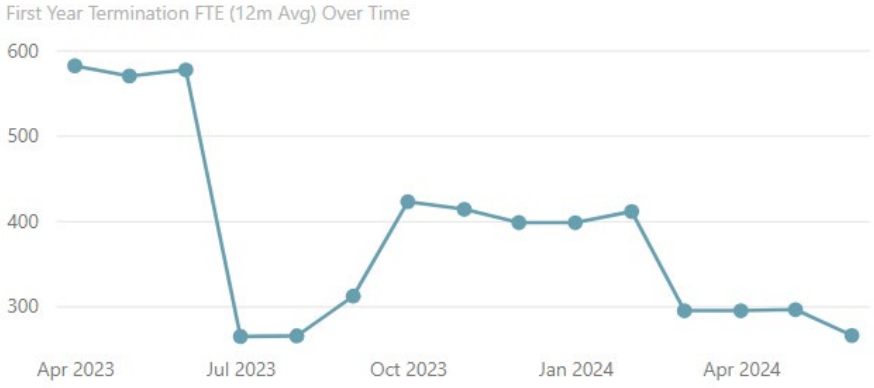
Group Turnover – Tenure of Leavers by Staff Group – Rolling 12 months.

		Tenure of Leavers HUTH			Tenure of Leavers NLAG		
Staff Group	**Less than 1 Year % of leavers Target**	**Less than 1 Year WTE**	**More than 1 Year WTE**	**Less than 1 Year % of leavers**	**Less than 1 Year WTE**	**More than 1 Year WTE**	**Less than 1 Year % of leavers**
Additional Clinical Services	15%	72.6	123.7	**37.60%**	44	164.1	**26.80%**
Add Prof Scientific and Technical	15%	2.2	12	**15.50%**	0	7.7	**0.00%**
Administrative and Clerical Staff	15%	53.9	136.6	**28.40%**	14.6	119.4	**12.20%**
Allied Health Professionals	15%	7.2	44.3	**13.90%**	9.4	52.9	**17.80%**
Estates and Ancillary	15%	19.4	43.6	**30.90%**	5.9	48.8	**12.10%**
Healthcare Scientists	15%	1	11.4	**8.10%**	1	15.4	**6.50%**
Medical & Dental - Consultant	15%	1.5	15.6	**8.70%**	1	7.5	**13.40%**
Medical & Dental - SAS	15%	1	5	**16.70%**	2	14	**14.30%**
Medica & Dental – Other	15%	0	0	**0.00%**	4	4.8	**46.50%**
Nursing and Midwifery Registered	15%	12.6	164.9	**7.10%**	12.3	137.9	**9.00%**
Students	15%	0	2	**0.00%**	0	0	**0.00%**
Trust Total	**15%**	**171.4**	**556.8**	**23.50%**	**94.2**	**482.29**	**16.40%**

Group Turnover and Tenure Comments

HUTH	NLAG
The Trust's current Turnover rate is 9.2% against a target of 10%.	The Trust's current Turnover rate is 10.3% against a target of 10%.
There is a high level of Turnover in Cancer Network, Patient Services, Chief Delivery Office, Pathology Network Group and Estates and Facilities Care Groups, these Care Groups are all above 12%	There is a high level of Turnover in Head & Neck, Major Trauma, Chief Delivery Office, Community, Frailty and Therapy, Specialist Medicine and Specialist Surgery, these Care Groups are all above 12%
There is a high level of Turnover in Additional Clinical Services, this Staff Groups are all above 12%	There is a high level of Turnover in Additional Clinical Services and Allied Health Professionals, these Staff Groups are all above 12%
The Trust has seen a 12 month average of 171.4 WTE (23.5% of leavers) that have left the Trust with less than 1 years' service	The Trust has seen a 12 month average of 94.20 WTE (15.6% of leavers) that have left the Trust within less than 1 years' service
The main Staff Groups that see Leavers within the 1st year of service are Admin & Clerical, Additional Clinical Services and Estates and Ancillary.	The main Staff Groups that see Leavers within the 1st year of service are Additional Clinical Services

Group Turnover over Time



Consultant and SAS Workforce – Job Plans

	HUTH % Signed off Job Plans			NLAG % Signed off Job Plans		
Health Group	**Target**	**Rate**	**Variance %**	**Target**	**Rate**	**Variance %**
Cancer Network	90.0	NA	NA	90.0	NA	NA
Cardiovascular	90.0	**48.6%**	41.4%	90.0	**0.0%**	90.0%
Digestive Diseases	90.0	**44.4%**	45.6%	90.0	**88.89%**	1.1%
Head & Neck	90.0	**71.4%**	18.6%	90.0	**54.6%**	35.5%
Major Trauma Network	90.0	**100.0%**	-10.0%	90.0	**100.0%**	-10.0%
Patient Services	90.0	NA	NA	90.0	NA	NA
Specialist Cancer and Support Services	90.0	**64.3%**	25.7%	90.0	**100.0%**	-10.0%
Chief Delivery Officer	90.0	NA	NA	90.0	NA	NA
Theatres, Anaesthetics and Critical Care	90.0	**91.0%**	-1.0%	90.0	**45.6%**	44.4%
Acute and Emergency Medicine	90.0	**66.7%**	23.3%	90.0	**72.6%**	17.4%
Community, Frailty & Therapy	90.0	**66.7%**	23.3%	90.0	**88.9%**	1.1%
Family Services	90.0	**58.7%**	31.3%	90.0	**37.9%**	52.1%
Neuroscience	90.0	**55.2%**	34.8%	90.0	**71.4%**	18.6%
Pathology Network Group	90.0	**81.8%**	8.2%	90.0	**85.7%**	4.3%
Site Management & Discharge Teams	90.0	NA	NA	90.0	NA	NA
Specialist Medicine	90.0	**76.9%**	13.1%	90.0	**82.4%**	7.6%
Specialist Surgery	90.0	**57.6%**	32.4%	90.0	**73.3%**	16.7%
Corporate	90.0	NA	NA	90.0	NA	NA
Estates, Facilities and Development	90.0	NA	NA	90.0	NA	NA

Group Sickness by Health Group

		% Sickness					
		HUTH			NLAG		
Health Group	Target	Rate	Long Term	Short Term	Rate	Long Term	Short Term
Cancer Network	4%	2.9%	1.5%	1.4%	5.6%	4.5%	1.1%
Cardiovascular	4%	3.3%	1.3%	2.0%	5.2%	3.6%	1.7%
Digestive Diseases	4%	3.8%	2.0%	1.8%	5.1%	3.2%	1.8%
Head & Neck	4%	3.2%	1.6%	1.6%	4.0%	2.5%	1.6%
Major Trauma Network	4%	5.5%	3.5%	2.0%	4.7%	2.7%	2.0%
Patient Services	4%	4.5%	2.8%	1.7%	6.1%	3.8%	2.3%
Specialist Cancer and Support Services	4%	3.2%	1.6%	1.5%	4.8%	2.9%	1.9%
Chief Delivery Officer	4%	0.9%	0.4%	0.5%	2.7%	1.6%	1.2%
Theatres, Anaesthetics and Critical Care	4%	4.7%	2.6%	2.1%	5.5%	3.3%	2.2%
Acute and Emergency Medicine	4%	4.7%	2.6%	2.1%	5.1%	2.3%	2.8%
Community, Frailty & Therapy	4%	3.1%	1.2%	2.0%	6.3%	3.8%	2.5%
Family Services	4%	4.8%	3.1%	1.7%	5.1%	3.2%	2.0%
Neuroscience	4%	3.7%	2.2%	1.5%	4.5%	2.6%	1.9%
Pathology Network Group	4%	5.6%	3.2%	2.4%	3.1%	1.6%	1.5%
Site Management & Discharge Teams	4%	4.8%	3.5%	1.4%	4.8%	3.0%	1.8%
Specialist Medicine	4%	4.6%	2.6%	2.0%	5.9%	3.7%	2.2%
Specialist Surgery	4%	4.1%	2.4%	1.7%	4.8%	2.8%	2.0%
Corporate	4%	3.4%	2.2%	1.1%	2.8%	1.7%	1.1%
Estates, Facilities and Development	4%	4.7%	3.3%	1.5%	5.8%	3.9%	1.9%
Trust Total	4%	4.0%	**2.2%**	**1.7%**	5.1%	**3.0%**	**2.0%**

Workforce Performance –Group Sickness by Staff Group

		% Sickness					
		HUTH			NLAG		
Staff Group	Target	Rate	Long Term	Short Term	Rate	Long Term	Short Term
Additional Clinical Services	4%	6.1%	3.5%	2.5%	7.2%	4.3%	2.9%
Add Prof Scientific and Technical	4%	2.6%	1.4%	1.2%	4.9%	3.5%	1.4%
Administrative and Clerical Staff	4%	3.5%	2.1%	1.4%	3.9%	2.4%	1.5%
Allied Health Professionals	4%	2.5%	1.0%	1.5%	4.0%	2.0%	1.9%
Estates and Ancillary	4%	5.2%	3.3%	1.9%	6.4%	4.4%	2.1%
Healthcare Scientists	4%	2.4%	1.1%	1.2%	3.0%	1.7%	1.3%
Medical & Dental - Consultant	4%	1.0%	0.8%	0.2%	2.4%	1.0%	1.1%
Medical & Dental - SAS	4%	0.6%	0.0%	0.6%	3.0%	1.6%	1.3%
Medical & Dental – Trainee Grades	4%	2.0%	0.6%	1.4%	2.3%	0.6%	1.7%
Nursing and Midwifery Registered	4%	4.6%	2.6%	2.0%	5.5%	3.3%	2.2%
Trust Total	4%	4.0%	**2.2%**	**1.7%**	5.1%	**3.0%**	**2.0%**

Workforce Performance – Appraisals by Health Group

	HUTH				NLAG			
	% Appraisal AFC Staff		% Medical PADR		% Appraisal AFC Staff		% Medical PADR	
Health Group	Target	Rate	Target	Rate	Target	Rate	Target	Rate
Cancer Network	85%	66.7%	90%	NA	85%	80.0%	90%	NA
Cardiovascular	85%	62.9%	90%	86.5%	85%	91.1%	90%	100.0%
Digestive Diseases	85%	65.9%	90%	89.7%	85%	81.0%	90%	83.0%
Head & Neck	85%	90.3%	90%	97.6%	85%	55.6%	90%	82.0%
Major Trauma Network	85%	83.8%	90%	100.0%	85%	88.0%	90%	67.0%
Patient Services	85%	77.7%	90%	NA	85%	74.5%	90%	NA
Specialist Cancer and Support Services	85%	72.7%	90%	NA	85%	80.9%	90%	100.0%
Chief Delivery Officer	85%	44.8%	90%	NA	85%	66.7%	90%	NA
Theatres, Anaesthetics and Critical Care	85%	78.5%	90%	92.8%	85%	77.2%	90%	92.0%
Acute and Emergency Medicine	85%	79.4%	90%	79.4%	85%	79.4%	90%	78.0%
Community, Frailty & Therapy	85%	78.8%	90%	100.0%	85%	84.1%	90%	71.0%
Family Services	85%	68.0%	90%	85.1%	85%	84.7%	90%	86.0%
Neuroscience	85%	61.8%	90%	100.0%	85%	93.6%	90%	86.0%
Pathology Network Group	85%	72.5%	90%	100.0%	85%	73.4%	90%	92.0%
Site Management & Discharge Teams	85%	67.3%	90%	NA	85%	62.0%	90%	NA
Specialist Medicine	85%	73.2%	90%	92.7%	85%	89.9%	90%	91.0%
Specialist Surgery	85%	71.1%	90%	88.5%	85%	77.3%	90%	75.0%
Corporate	85%	64.6%	90%	100.0%	85%	73.5%	90%	100.0%
Estates, Facilities and Development	85%	87.6%	90%	NA	85%	92.2%	90%	NA

Workforce Performance – Appraisals by Staff Group

	HUTH				NLAG			
	% Appraisal AFC Staff		% Medical PADR		% Appraisal AFC Staff		% Medical PADR	
Staff Group	**Target**	**Rate**	**Target**	**Rate**	**Target**	**Rate**	**Target**	**Rate**
Additional Clinical Services	85%	**73.5%**	NA	NA	85%	**83.0%**	NA	NA
Add Prof Scientific and Technical	85%	**78.4%**	NA	NA	85%	**83.1%**	NA	NA
Administrative and Clerical Staff	85%	**69.5%**	NA	NA	85%	**74.3%**	NA	NA
Allied Health Professionals	85%	**78.5%**	NA	NA	85%	**81.8%**	NA	NA
Estates and Ancillary	85%	**83.4%**	NA	NA	85%	**92.6%**	NA	NA
Healthcare Scientists	85%	**74.8%**	NA	NA	85%	**68.3%**	NA	NA
Medical & Dental	NA	NA	90%	**91.4%**	NA	NA	90%	**84.0%**
Nursing and Midwifery Registered	85%	**74.2%**	NA	NA	85%	**81.4%**	NA	NA
Trust Total	**85%**	**74.2%**	**90%**	**91.4%**	**85%**	**80.9%**	**90.0%**	**84.0%**

Workforce Performance – Core and role specific mandatory training by Health Group

	HUTH				NLAG			
	Core		Role Specific		Core		Role Specific	
Health Group	**Target**	**Rate**	**Target**	**Rate**	**Target**	**Rate**	**Target**	**Rate**
Cancer Network	85%	87.9%	85%	82.8%	85%	96.8%	85%	95.3%
Cardiovascular	85%	76.9%	85%	70.4%	85%	92.9%	85%	88.2%
Digestive Diseases	85%	86.7%	85%	74.3%	85%	86.6%	85%	78.0%
Head & Neck	85%	92.0%	85%	79.0%	85%	87.9%	85%	70.3%
Major Trauma Network	85%	94.7%	85%	85.5%	85%	95.3%	85%	87.2%
Patient Services	85%	95.2%	85%	88.7%	85%	95.2%	85%	85.5%
Specialist Cancer and Support Services	85%	90.3%	85%	79.1%	85%	93.6%	85%	89.1%
Chief Delivery Officer	85%	90.2%	85%	61.8%	85%	94.0%	85%	100.0%
Theatres, Anaesthetics and Critical Care	85%	93.0%	85%	82.4%	85%	87.9%	85%	78.4%
Acute and Emergency Medicine	85%	88.9%	85%	78.5%	85%	85.5%	85%	75.5%
Community, Frailty & Therapy	85%	89.8%	85%	77.1%	85%	90.7%	85%	80.4%
Family Services	85%	91.5%	85%	78.5%	85%	85.4%	85%	80.6%
Neuroscience	85%	82.4%	85%	69.3%	85%	88.1%	85%	78.6%
Pathology Network Group	85%	89.3%	85%	68.9%	85%	87.4%	85%	78.9%
Site Management & Discharge Teams	85%	90.2%	85%	79.7%	85%	90.8%	85%	72.1%
Specialist Medicine	85%	88.9%	85%	75.7%	85%	89.6%	85%	81.6%
Specialist Surgery	85%	84.6%	85%	71.0%	85%	92.1%	85%	75.7%
Corporate	85%	85.6%	85%	68.7%	85%	92.1%	85%	69.1%
Estates, Facilities and Development	85%	96.8%	85%	92.8%	85%	96.3%	85%	93.4%

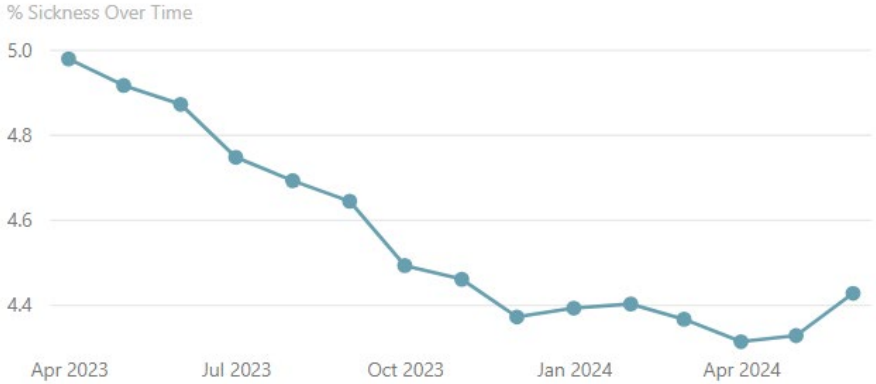
Workforce Performance – Core and Role Specific by Staff Group

	HUTH				NLAG			
	Core		Role Specific		Core		Role Specific	
Health Group	**Target**	**Rate**	**Target**	**Rate**	**Target**	**Rate**	**Target**	**Rate**
Additional Clinical Services	85%	**89.0%**	85%	**70.0%**	85%	**90.9%**	85%	**77.7%**
Add Prof Scientific and Technical	85%	**91.2%**	85%	**82.1%**	85%	**95.9%**	85%	**89.4%**
Administrative and Clerical Staff	85%	**93.4%**	85%	**88.8%**	85%	**95.9%**	85%	**63.8%**
Allied Health Professionals	85%	**92.1%**	85%	**80.3%**	85%	**92.7%**	85%	**85.1%**
Estates and Ancillary	85%	**95.7%**	85%	**91.1%**	85%	**95.4%**	85%	**93.4%**
Healthcare Scientists	85%	**92.8%**	85%	**76.9%**	85%	**89.0%**	85%	**78.3%**
Medical & Dental – Consultant	85%	**85.2%**	85%	**75.6%**	85%	**81.0%**	85%	**71.0%**
Medical & Dental – SAS	85%	**80.4%**	85%	**69.1%**	85%	**75.3%**	85%	**65.0%**
Medical & Dental – Trainee Grades	85%	**75.8%**	85%	**70.9%**	85%	**59.4%**	85%	**47.7%**
Nursing and Midwifery Registered	85%	**91.5%**	85%	**79.5%**	85%	**90.8%**	85%	**84.6%**
Trust Total	**85%**	**89.8%**	**85%**	**77.2%**	**85%**	**90.9%**	**85%**	**80.2%**

Workforce Performance Group Summary

HUTH	NLAG
The Trust is currently meeting the sickness target (4%) of 4%.	The Trust is currently not meeting the sickness target (5.1%) of 4%.
All Staff Groups are below the Trust target	Additional Clinical Services (7.20%), Add Prof Scientific and Technical (4.9%), Estates and Ancillary (6.4%), and Nursing and Midwifery Registered (5.5%) are all above the Trust target
Appraisals (74.2%) The Trust is 10.8% below the target for AfC staff appraisals and is 1.4% above the target for Cons/SAS appraisals (91.4%)	Appraisals (80.9%) The Trust is 4.1% below the target for AfC staff appraisals and is 6% below the target for Cons/SAS appraisals (84%)
Core Mandatory Training – The Trust is 4.8% above the Trust target of 85%	Core Mandatory Training – The Trust is 5.9% above the Trust target of 85%
Role Specific Training – The Trust is 7.8% below the Trust target of 85%	Role Specific Training – The Trust is 4.8% below the Trust target of 85%

Group Sickness over Time



Workforce Performance – Recruitment KPI's

		HUTH			NLAG		
	Group	**General Staffing**	**Medical Staffing**	**All Staffing**	**General Staffing**	**Medical Staffing**	**All Staffing**
Appointing Manager Metrics	T4- Time Taken to Shortlist (Target 5 working days)	9.4	11.2	10.3	4	5	5
	T5b- Time taken to provide interview outcome (Target 2 working days)	3.7	7	5.35	2	5	4
Recruitment Team Metrics	T11 - Time to Hire (Conditional offer to Checks OK) (Target 20 working days)	25	44	35	22	34	24

Recruitment KPI Overview	HUTH	NLAG	Total
Number of Active Vacancies	136	139	275
Number of Applications received	2791	2557	5348
Number of Conditional Offers Issued	107	152	259
Number of New Starters Headcount*	112	152	264

*New Starters are demonstrated as headcount and will include Bank Staff that are represented as 0WTE

Culture Indicators

	HUTH				NLAG			
Indicator	**Most Recent Score**	**Previous Score Q2**	**Previous Score Q1**	**Previous Score Q4**	**Most Recent Score**	**Previous Score Q2**	**Previous Score Q1**	**Previous Score Q4**
Friends & Family Staff – Care of Treatment (Quarterly)	TBC	TBC	TBC	TBC	35.90%	52.03%	48.0%	48.60%
Friends & Family Staff – Place to Work (Quarterly)	TBC	54.70%	50.50%	49.20%	28.2%	52.95%	41.7%	41.7%

Staff Survey

	HUTH				NLAG			
Theme	**Trust**	**Best**	**Average**	**Worst**	**Trust**	**Best**	**Average**	**Worst**
We are compassionate and inclusive	7.15	7.71	7.24	6.85	7.03	7.71	7.24	6.85
We are recognised and rewarded	5.87	6.37	5.94	5.5	5.76	6.37	5.94	5.5
We each have a voice that counts	6.51	7.16	6.7	6.21	6.52	7.16	6.7	6.21
We are safe and healthy	6.01	6.55	6.06	5.75	5.99	6.55	6.06	5.75
We are always learning	5.69	6.07	5.61	5.05	5.39	6.07	5.61	5.05
We work flexibility	5.99	6.87	6.2	5.6	5.82	6.87	6.2	5.6
We are a team	6.61	7.19	6.75	6.35	6.49	7.19	6.75	6.35
Staff Engagement	6.66	7.32	6.91	6.34	6.65	7.32	6.91	6.34
Morale	5.88	6.52	5.91	5.54	5.84	6.52	5.91	5.54

Glossary - Staff Groups and Roles

Staff Group	Example Roles
Add Scientific and Tech Staff	ACPs Chaplain Optometrist Pharmacist Pharmacy Technicians Physician Associate
Additional Clinical Services	Dental Surgery Assistant Healthcare Assistant Pre-reg Pharmacist Health Care Support Worker Healthcare Science Assistant Nursing Associate Phlebotomist Trainee Healthcare Science Practitioner Trainee Healthcare Scientist Trainee Nursing Associate Trainee Practitioner

Staff Group	Example Roles
Administrative	Accountant Chief Executive and Exec Directors Managers and Senior Managers Clerical Worker and Officers
AHPs	Dietitian Occupational Therapist Orthoptist Physiotherapist Radiograper - Diagnostic and Therapeutic Speech and Language Therapist
Estates and Ancillary	Building Craftsperson Building Officer Cook Gardener/Groundsperson Housekeeper Maintenance Craftsperson Porter

Staff Group	Example Roles
Healthcare Scientists	Consultant Healthcare Scientist Healthcare Science Practitioner Healthcare Scientist (e.g. BMS)
Medical Staff	Consultants SAS Trainee Grades
Registered Nurses	Staff Nurse Sister/Charge Nurse Midwife Modern Matron

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)076

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	11 April 2024
Director Lead	David Sharif, Group Director of Assurance
Contact Officer / Author	As Above
Title of Report	Documents Signed Under Seal
Executive Summary	The report below provides details of documents signed under Seal since the date of the last report provided in April 2024. The report includes documents sealed by Northern Lincolnshire & Goole (NLaG) NHS Foundation Trust and Hull University Teaching Hospital (HUTH) NHS Trust
Background Information and/or Supporting Document(s) (if applicable)	This is a routine report in the agreed format
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	Not directly
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

Use of Trust Seal – August 2024

Introduction

Standing order 60.3 requires that the Trust Board receives reports on the use of the Trust Seal.

60.3 Register of Sealing

"An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the Seal. (The report shall contain details of the seal number, the description of the document and date of sealing)".

The Trust's Seal at NLaG has been used on the following occasions:

Seal Register Ref No.	Description of Document Sealed	Seal Signed by	Date of Sealing
284	Gym Roofing Works at Scunthorpe General Hospital (SGH) RAAC Removal	Jonathan Lofthouse	11.04.2024
285	Licence to Alter Grimsby Community Diagnostic Centre (CDC)	Jonathan Lofthouse & Lee Bond	22.05.2024

The Trust's Seal at HUTH has been used on the following occasions:

Seal Register Ref No.	Description of Document Sealed	Seal Signed by	Date of Sealing
2023/08	Hull University Teaching Hospitals (HUTH) NHS Trust and Humber NHS FT – Lease relating to premises on the ground floor at Hull Royal Infirmary	Jonathan Lofthouse & Lee Bond	14.11.2023
2023/09	NLAG and Fresenius Medical Care Renal Services Ltd, HUTH NHS Trust, GTC Pipelines Ltd and ES Living (Grimsby) Ltd – Deed of grant relating to land at the Renal Dialysis Unit at Diana Princess of Wales Hospital (DPoW)	Jonathan Lofthouse & Lee Bond	14.11.2023
2023/10	HUTH NHS Trust and Hobson and Porter – The replacement and installation of a new MRI to the existing MRI 2 Suite and associated Ancillary	Jonathan Lofthouse & Lee Bond	21.11.2023

Seal Register Ref No.	Description of Document Sealed	Seal Signed by	Date of Sealing
	Rooms including Mechanical and Electrical Services and drainage installations		
2024/01	NLaG NHS Foundation Trust – contract documents for Scunthorpe Community Diagnostics Centre (shell and core) Feb 2024	Jonathan Lofthouse & Lee Bond	12.04.2023

Action Required

The Trust Boards-in-Common are asked to note the report.

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)167

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	8 August 2024
Director Lead	David Sharif, Group Director of Assurance
Contact Officer/Author	David Sharif, Group Director of Assurance
Title of the Report	Trust Boards-in-Common & Committees Meeting Cycle
Executive Summary	The attached schedule provides the planned dates and times of Trust Boards and Committees-in-Common meetings for the period between January 2024 and December 2024. The report also includes the schedule for January - December 2025.
Background Information and/or Supporting Document(s) (if applicable)	This is a routine report in the agreed format.
Prior Approval Process	None
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

MEETING SCHEDULE - 2024 - V15

MEETING	Quarter 4 (23/24) Jan	Feb	Mar	Quarter 1 (24/25) Apr	May	Jun	Quarter 2 (24/25) Jul	Aug	Sep	Quarter 3 (24/25) Oct	Nov	Dec
Trust Board												
Public & Private (Thursdays - 9.00 am - 5.00 pm)		08.02.24		11.04.24		13.06.24		08.08.24		10.10.24		12.12.24
Board Development (Tuesdays - 9.00 am - 5.00 pm)	02.01.24		05.03.24		14.05.24		02.07.24				05.11.24	
Committees in Common												
Performance, Estates & Finance (Wednesdays - 9.00 am - 12.30 pm)	24.01.24	28.02.24	27.03.24	24.04.24	29.05.24	26.06.24	24.07.24	28.08.24	25.09.24	30.10.24	27.11.24	18.12.24
Capital & Major Projects (Tuesdays - 9.00 am - 12.00 pm)		20.02.24		23.04.24		25.06.24		27.08.24		29.10.24	26.11.24	
Quality & Safety (Thursdays - 9.00 am - 12.30 pm with exceptions as stated)	25.01.24 (1.30 pm - 5.00 pm)	29.02.24	28.03.24	25.04.24 (1.30 pm - 5.00 pm)	23.05.24	27.06.24	31.07.24 (Wednesday)	29.08.24	26.09.24	24.10.24	28.11.24	17.12.24 (Tuesday)
Remuneration (Thursdays - 9.00 am - 11.30 am)	11.01.24			04.04.24	28.05.24 (Tuesday - 11.00 - 12.00)	19.06.24 (Wednesday - 11.00 - 12.30)				03.10.24		
Workforce, Education & Culture (Thursdays - 1.30 pm - 5.00 pm with exceptions as stated)	30.01.24 (Tuesday - 9.00 am - 12.30 pm)	29.02.24	28.03.24	30.04.24 (Tuesday - 9.00 am - 12.30 pm)	23.05.24	27.06.24	25.07.24	29.08.24	26.09.24	24.10.24	28.11.24	
Audit, Risk & Governance Committee (Thursdays - 9.00 am - 12.30 pm with exceptions as stated)	25.01.24			25.04.24		21.06.24 (Friday - 9.00 am - 10.30 am) **HUTH ONLY**	25.07.24	06.08.24 (Tuesday - 9.00 am - 10.30 am) **NLAG ONLY**		31.10.24		
Charitable Funds												
NLAG (9.00 am - 12.00 pm)	10.01.24			03.04.24			04.07.24			09.10.24		
HUTH (9.00 am - 12.00 pm)		21.02.24			30.05.24			22.08.24			13.11.24	
Executive Team Meetings												
Executive Team (Tuesdays - 2.00 pm - 5.00 pm)	09.01.24 16.01.24 23.01.24 30.01.24	06.02.24 13.02.24 20.02.24 27.02.24	12.03.24 19.03.24 26.03.24	02.04.24 09.04.24 16.04.24 23.04.24 30.04.24	14.05.24 21.05.24 28.05.24	04.06.24 11.06.24 18.06.24 25.06.24	09.07.24 16.07.24 23.07.24 30.07.24	06.08.24 13.08.24 20.08.24 27.08.24	10.09.24 17.09.24 24.09.24	01.10.24 08.10.24 15.10.24 22.10.24 29.10.24	12.11.24 19.11.24 26.11.24	03.12.24 10.12.24 17.12.24 24.12.24
Site Review Meetings												
North Site Review					30.05.24	24.06.24	29.07.24	21.08.24	23.09.24	28.10.24	25.11.24	23.12.24
South Site Review					30.05.24	24.06.24	29.07.24	21.08.24	23.09.24	28.10.24	25.11.24	23.12.24
Governors												
Council of Governors (Thursdays - Business Meetings - 2.00 pm - 5.00 pm, with exceptions as stated)	11.01.24			18.04.24 (9.30 am - 12.30 pm)		18.06.24 **Business Meeting** 9.00 am - 12.00 pm		**Annual Review Meeting** 22.08.24	**Annual Members Meeting** 12.09.24	31.10.24		
Member & Public Engagement & Assurance Group (MPEAG) (Tuesdays - 5.30 pm - 7.00 pm with exceptions as stated)		15.02.24 (Thursday)			21.05.24		16.07.24		24.09.24			
Appointments & Remuneration Committee (Thursdays - 1.30 pm - 3.00 pm)			14.03.24		30.05.2024 (2.30 pm - 4.00 pm)					03.10.24		
NED & CEO Meetings												
NED & CEO Meetings (Thursdays - 2.00 pm - 4.00 pm - with exceptions as stated)	09.01.24 (Tuesday - 10.00 am-12.00 pm)	15.02.24	14.03.24 (10.00 am-12.00 pm)		16.05.24	19.06.24 (Wednesday)	09.07.24 (Tuesday - 10.00 am - 12.00 pm)	15.08.24	10.09.24 (Tuesday - 10.00 am - 12.00 pm)	15.10.24	14.11.24	19.12.24
Union Meetings												
JNCC - NLAG (Mondays - 2.30 pm - 4.30 pm)	15.01.24	19.02.24	18.03.24	15.04.24	20.05.24	17.06.24	15.07.24	19.08.24	16.09.24	21.10.24	18.11.24	16.12.24
JNCC - HUTH (Thursdays - 10.45 am - 12.45 pm)	04.01.24		07.03.24		02.05.24		04.07.24		05.09.24		07.11.24	
Consultant Meetings												
JLNC - NLAG (Tuesdays - 1.00 pm - 3.00 pm)	16.01.24	20.02.24	19.03.24	16.04.24	21.05.24	18.06.24	16.07.24	20.08.24	17.09.24	15.10.24	19.11.24	17.12.24
LNC - HUTH (Wednesdays - 10.00 am - 12.00 pm)	17.01.24		20.03.24		15.05.24		17.07.24		18.09.24		20.11.24	

MEETING SCHEDULE - 2025 - V5

	Quarter 4 (24/25)			Quarter 1 (25/26)			Quarter 2 (25/26)			Quarter 3 (25/26)		
MEETING	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Trust Board												
Public & Private (Thursdays - 9.00 am - 5.00 pm)		13.02.25 **Boardroom, HRI**		10.04.25 **Boardroom, DPOW**		12.06.25 **Boardroom, HRI**		14.08.25 **Boardroom, DPOW**		09.10.25 **Boardroom, HRI**		11.12.25 **Boardroom, DPOW**
Board Development (Tuesdays - 9.00 am - 5.00 pm)			13.03.25 **Boardroom, DPOW**		08.05.25 **Boardroom, HRI**		10.07.25 **Boardroom, DPOW**		11.09.2025 **Boardroom, HRI**		13.11.25 **Boardroom, DPOW**	
Committees in Common												
Performance, Estates & Finance (Tuesdays - 9.00 am - 12.30 pm)	Meeting falls in December 2024 due to previous reporting cycle	04.02.25 **Boardroom, DPOW**	04.03.25 **Boardroom, HRI**	01.04.25 **Nightingale, SGH**	06.05.25 **Boardroom, HRI**	03.06.25 **TBC, CHH**	01.07.25 **Boardroom, DPOW**	05.08.25 **Nightingale, SGH**	02.09.25 **Boardroom, HRI**	30.09.25 **(please note falls in September)** **TBC, CHH**	04.11.25 **Boardroom, DPOW**	02.12.2025 **Nightingale, SGH**
Capital & Major Projects (9.00 am - 12.00 pm)		19.02.25 **Nightingale, SGH**		22.04.25 **Boardroom, HRI**		18.06.25 **Boardroom, DPOW**		20.08.25 **Nightingale, SGH**		22.10.25 **Boardroom, HRI**		16.12.25 **Boardroom, HRI**
Quality & Safety (Thursdays - 9.00 am - 12.30 pm with exceptions as stated)	30.01.25 **TBC, CHH**	27.02.25 **Nightingale, SGH**	27.03.25 **Boardroom, DPOW**	29.04.25 **Boardroom, HRI**	29.05.25 **TBC, CHH**	26.06.25 **Nightingale, SGH**	24.07.25 **Boardroom, HRI**	28.08.25 **Boardroom, DPOW**	25.09.25 **TBC, CHH**	30.10.25 **Nightingale, SGH**	27.11.25 **Boardroom, HRI**	18.12.25 **Boardroom, DPOW**
Remuneration - (Virtual Meeting) (9.00 am - 11.30 am)		05.02.25			27.05.25			06.08.25			20.11.25	
Workforce, Education & Culture (Wednesdays - 9.00 am - 12.30 pm)	29.01.25 **Boardroom, DPOW**	26.02.25 **Boardroom, HRI**	26.03.25 **Nightingale, SGH**	30.04.25 **TBC, CHH**	28.05.25 **Boardroom, DPOW**	25.06.25 **Boardroom, HRI**	23.07.25 **Nightingale, SGH**	27.08.25 **TBC, CHH**	24.09.25 **Boardroom, DPOW**	29.10.25 **Boardroom, HRI**	26.11.25 **Nightingale, SGH**	17.12.25 **TBC, CHH**
Audit, Risk & Governance Committee (Thursdays - 9.00 am - 12.30 pm with exceptions as stated)	23.01.25 **Boardroom, HRI**			24.04.25 **Boardrom, HRI**		20.06.25 HUTH & NLaG **Annual Accounts** Friday - 9.00 am - 12.00 pm **Boardroom, HRI**	31.07.25 **Boardroom, DPOW**				12.11.25 **TBC, CHH**	
Charitable Funds												
NLAG (9.00 am - 12.00 pm)	22.01.25			02.04.25			09.07.25			01.10.25		
HUTH (9.00 am - 12.00 pm)		06.02.25			07.05.25			07.08.25			06.11.25	
Executive Team Meetings												
Executive Team (Tuesdays - 2.00 pm - 5.00 pm)	07.01.25 14.01.25 21.01.25 28.01.25	04.02.25 11.02.25 18.02.25 25.02.25	11.03.25 18.03.25 25.03.25	01.04.25 08.04.25 15.04.25 22.04.25 29.04.25	13.05.25 20.05.25 27.05.25	03.06.25 10.06.25 17.06.25 24.06.25	08.07.25 15.07.25 22.07.25 29.07.25	05.08.25 12.08.25 19.08.25 26.08.25	09.09.25 16.09.25 23.09.25 30.09.25	07.10.25 14.10.25 21.10.25 28.10.25	11.11.25 18.11.25 25.11.25	02.12.25 09.12.25 16.12.25 23.12.25
Governors												
Council of Governors (2.00 pm - 5.00 pm, with exceptions as stated)	09.01.25	25.02.25 (9.00 am - 10.30 am) **NED & Governor only Meeting**		16.04.25			17.07.25		04.09.25 (1.30 pm - 5.00 pm) **AMM & Highlight Reports**		05.11.25	
Member & Public Engagement & Assurance Group (MPEAG) (Tuesdays - 5.30 pm - 7.00 pm)			11.03.25			03.06.25				07.10.25		02.12.25
Appointments & Remuneration Committee (Thursdays - 3.00 pm - 4.30 pm)		20.02.25			29.05.25				25.09.25			
NED & CEO Meetings												
NED & CEO Meetings (Tuesdays - 10.00 am - 12.00 pm)	14.01.25	18.02.25	18.03.25	15.04.25	13.05.25	17.06.25	15.07.25	19.08.25	16.09.25	14.10.25	18.11.25	09.12.25
Union Meetings												
JNCC - NLAG (Mondays - 2.30 pm - 4.30 pm)	20.01.25	17.02.25	17.03.25	21.04.25	19.05.25	16.06.25	21.07.25	18.08.25	15.09.25	20.10.25	17.11.25	15.12.25
JNCC - HUTH (Thursdays - 10.45 am - 12.45 pm)	02.01.25		06.03.25		01.05.25		03.07.25		04.09.25		06.11.25	
Consultant Meetings												
JLNC - NLAG (Tuesdays - 12.30 pm - 2.00 pm)	21.01.25	18.02.25	18.03.25	15.04.25	20.05.25	17.06.25	15.07.25	19.08.25	16.09.25	21.10.25	18.11.25	16.12.25
LNC - HUTH (Wednesdays - 10.00 am - 1.00 pm)	15.01.25		19.03.25		21.05.25		16.07.25		17.09.25		19.11.25	

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)168

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**8 August 2024**
Director Lead	Neil Gammon, Independent Chair of Committee
Contact Officer / Author	Lee Bond, Group Chief Financial Officer
Title of Report	**Health Tree Foundation Annual Report & Accounts 2023/24**
Executive Summary	The Annual Report & Accounts for 2023/24 are enclosed for information.
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	
Financial Implication(s) (if applicable)	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

Contact

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Goole:

The Health Tree Foundation
Goole & District Hospital,
Woodland Avenue, Goole,
DN14 6RX

Scunthorpe:

The Health Tree Foundation
Scunthorpe General Hospital,
Cliff Gardens, Scunthorpe,
DN15 7BH

Grimsby:

The Health Tree Foundation
Diana, Princess of Wales
Hospital, Scartho Road,
Grimsby, DN33 2BA

The Health Tree Foundation
is the working name of the Northern
Lincolnshire and Goole NHS Foundation Charitable
Funds. The principal address is: Diana, Princess of
Wales Hospital, Scartho Road, Grimsby, North East
Lincolnshire, DN33 2BA

Registered charity number: 1054935

THE HEALTH TREE FOUNDATION

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Inspiring change in your NHS

Annual Report
2023/2024

Contents

Welcome to our Annual Report for 2023/24

We have had an incredible year and that is thanks to you – our local communities, businesses and supporters.

The support we have received has been heart-warming – you have come together to support your local hospitals and community health services. We have been overwhelmed and humbled by the generosity you have all shown.

You have rallied together to support your NHS whether that be donating wonderful gifts to both staff and patients, volunteering your time to help improve your hospitals, or contributing monetary donations.

We could not have achieved what we have this year without the continuous support of our corporate supporters, volunteers, crafters, bakers, fundraisers and those who have kindly remembered us in their Will.

Thank you so much to each and every one for the continued support you provide to your local hospitals. Your help will always be remembered and will be a lasting part of your local hospital for years to come.

Lucy Skipworth
Charity Manager
The Health Tree Foundation

Clare Woodard
Head of Business Development
HEY Smile Foundation

A Message from our Chair

It's hard to think that a year has passed since I last wrote a Foreword to the Health Tree Foundation Annual Report. In that time, your charity has gone from strength to strength. It's "your" charity because Health Tree Foundation exists to enhance the patient experience for everyone who is cared for by the Northern Lincolnshire and Goole NHS Foundation Trust. That person may be an in-patient, out-patient or a patient in the community. This is achieved by using donations and grant monies to provide enhancements, facilities and various items that would not normally be provided by core NHS funds. If you, as a patient, carer, family member, visitor or staff member have an idea for an improvement, then do get in touch with "your" charity and Make a Wish! The Health Tree Foundation Team will help you every step of the way.

But Wishes cannot exist without "your" generosity and I want to thank everyone who donates to the Health Tree Foundation. That may be a simple monetary gift, perhaps a thank you for great care, an organised fundraising event, a local business sponsorship or possibly a legacy. No matter how it is achieved, your valued support is vital. It is vital so that HTF can enhance the new hospital Emergency Departments, can help to make more Trust aspects dementia friendly, can launch appeals such as those for the new Scunthorpe and Grimsby Community Diagnostic Centres, and make an everyday difference with the many, minor enhancements that have been introduced throughout the Trust this year.

Please take time to browse this report, see the good that is done, see the generosity and inventiveness displayed and see the genuine kindness that shines forth.

Finally, please accept my humble appreciation and thanks together with that of my fellow Trustees and the Foundation Team for everyone's support for "your' charity, the Health Tree Foundation.

Neil Gammon

Independent Chair of Health Tree Foundation Trustees' Committee

A Message from our Patron

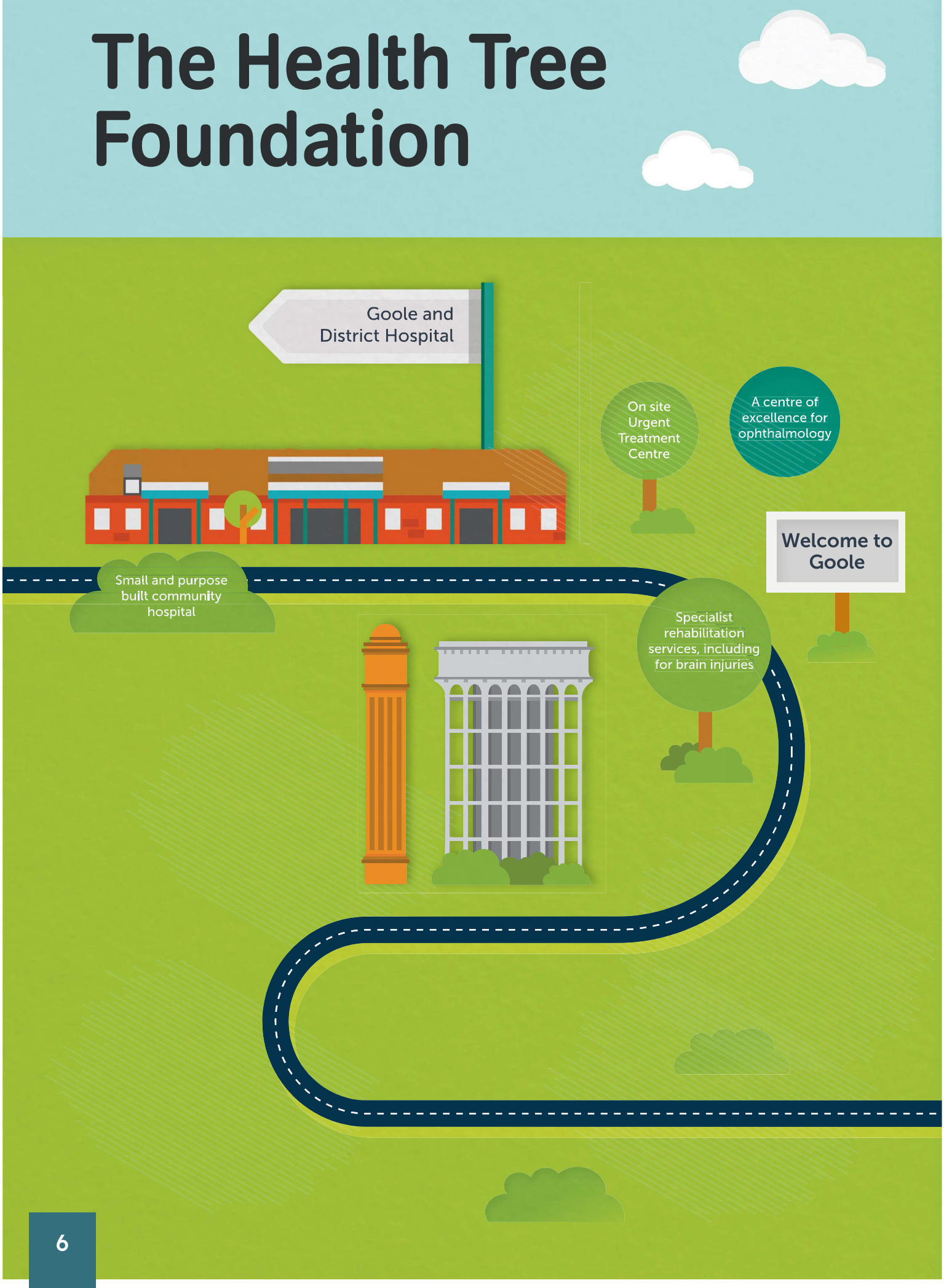
As I said in last year's Annual Report, it has been an absolute delight to be associated with The Health Tree Foundation as your Patron and it is hard to believe that my 3 year tenure has come to an end. Like all of you, my family and I are users of the wonderful NHS facilities that The Northern Lincolnshire and Goole NHS Foundation Trust provides. I have been very pleased to see the £65 million investment that is being made across our hospitals and community services. That has provided an opportunity for The Health Tree Foundation to enhance these new areas with some extras to improve patient experiences; items such as charging points, skylight ceiling tiles and attractive wall murals. In addition, younger patients are catered for with games and toys to keep them entertained and at ease whilst they wait to be seen. These are all items which the NHS would not fund from core monies and the fact that such purchases can be made is thanks to our army of fundraisers and those individuals and corporate or social groups who donate in so many other ways. Even during these difficult, personal financial times for many of you, the Health Tree Foundation funds are continually topped up, for which I thank every one of you, patients, families and staff members alike.

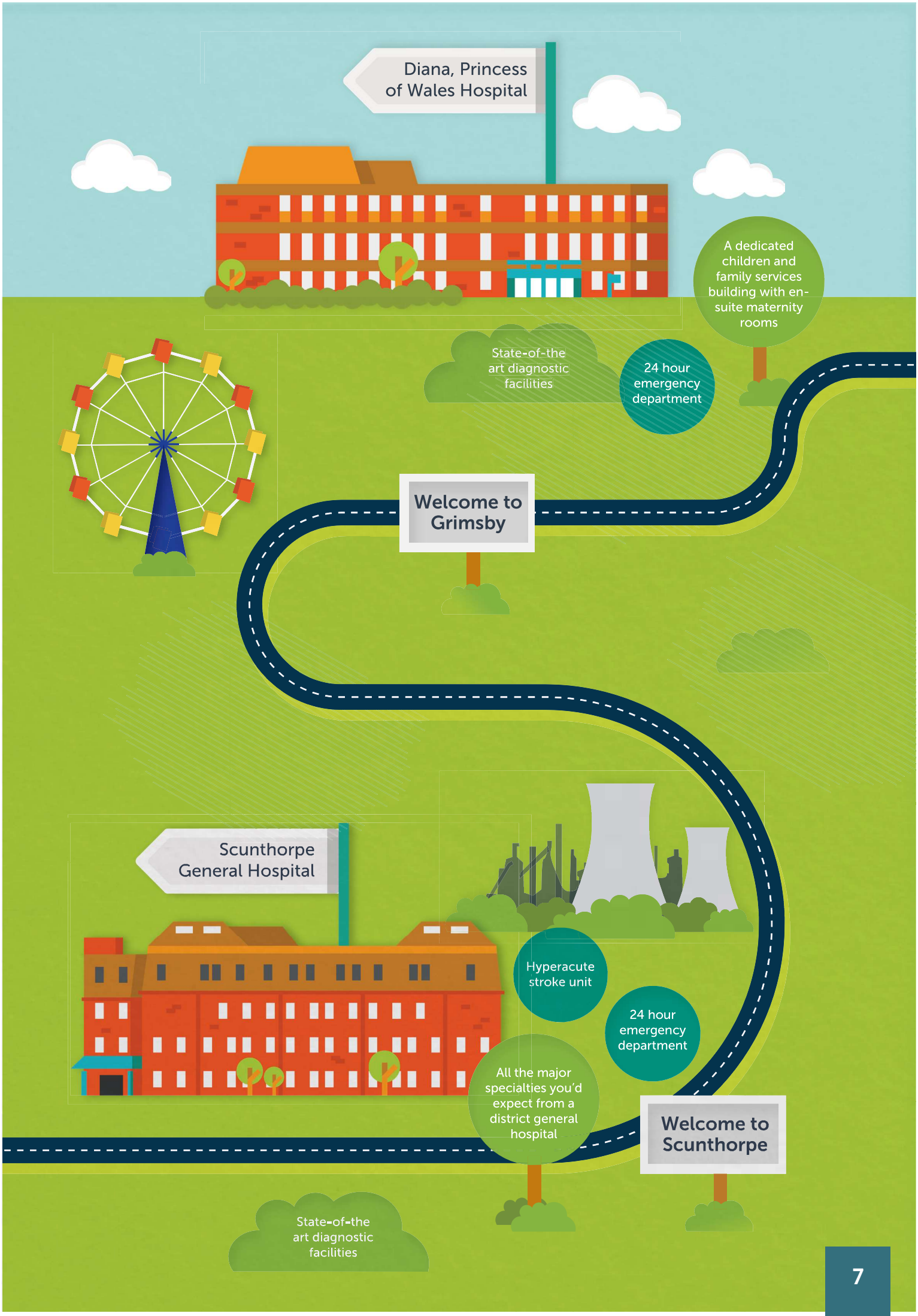
May I ask you to maintain this wonderful support as the Trust moves forward and please encourage others to join in this selfless activity. I am confident that your Trust charity will go from strength to strength with such backing. Thank you again.

Sir Reginald Adrian Berkeley Sheffield

8th Baronet DL

The Health Tree Foundation




Diana, Princess of Wales Hospital
A dedicated children and family services building with en-suite maternity rooms
State-of-the art diagnostic facilities
24 hour emergency department
Welcome to Grimsby
Scunthorpe General Hospital
Hyperacute stroke unit
24 hour emergency department
All the major specialties you'd expect from a district general hospital
Welcome to Scunthorpe
State-of-the art diagnostic facilities

Meet Scrubs!

Scrubs the Bear is the large and cuddly mascot for NHS charity The Health Tree Foundation (HTF).

Don't be alarmed if you spot Scrubs at your local hospital! He will be there to entertain youngsters on the children's wards, warm the hearts of the Trust's adult patients, and encourage the communities to raise funds for each hospital.

About us

At The Health Tree Foundation, we will ensure that funds, however big or small, are used to make a positive difference to our community's healthcare.

With invaluable support from our local communities, the Health Tree Foundation charity works in partnership with the Northern Lincolnshire and Goole NHS Foundation Trust.

Your help means we can provide acute hospital and community services to a population of over 400,000 people across North and North East Lincolnshire and the East Riding of Yorkshire.

We hope to inspire, engage, and channel the charitable intent of your local community, helping to turn donations of time and money into making your NHS Sparkle.

Our Vision

A community in which everyone can benefit from the best healthcare in the UK.

Our Mission

We inspire, engage and channel the charitable intent of people, helping them to donate and make a real difference to the quality of people's health care where it really matters.

Our Promise

Above all we will ensure that funds, however big or small, are used to the best effect to make a positive difference to our community's healthcare.

Highlights of the year 2023/2024

From on-line fundraising events to skydiving events and everything in between. Here are some of the highlights of the year.

Move More Launch

March

Diana Princess of Wales Hospital, Grimsby

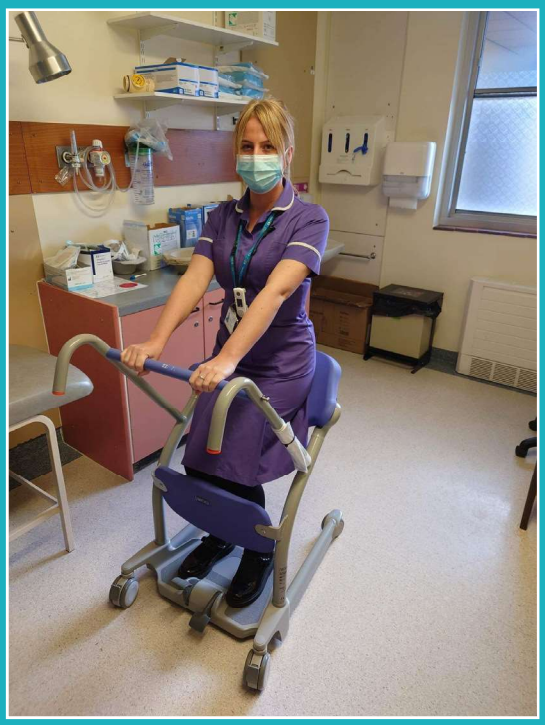
The Health Tree Foundation team launched their Move More In March campaign to encourage the local community to move more and raise funds for our Little Lives Appeal, Trustwide. Keelby Primary School took part in this event and even got a visit from our mascot, Scrubs the Bear. The pupils in the school raised over £500, well done!

New Equipment - Sara Stedy for SDEC and IAAU!

Diana Princess of Wales Hospital, Grimsby

March

Thanks to your donations, we have been able to purchase a Sara Stedy for SDEC and IAAU. Patients in our care in hospital who need support standing but do not require a hoist can benefit from a Sara Stedy. This standing aid helps to make the transfer of patients much safer and is a great help to nurses. This equipment also encourages patient's independence to stand aided.



An Amazing Gift In Kind

March

Diana Princess of Wales Hospital, Grimsby

The Health Tree Foundation received an amazing Gift In Kind from Mr and Mrs Bell. This incredible portrait of Princess Diana which has been created using stamps! Mr and Mrs Bell first set eyes on this beautiful piece of artwork whilst abroad on holiday and just couldn't leave it behind and brought it back to the UK. This stunning picture now proudly hangs in the main entrance of Diana Princess of Wales Hospital, Grimsby!

Easter Deliveries

All sites

April

Over the Easter period, we received so many kind and generous gifts for all the children who are spending Easter in our hospitals. Thank you so much for all the kind donations and visits!

Move More Launch

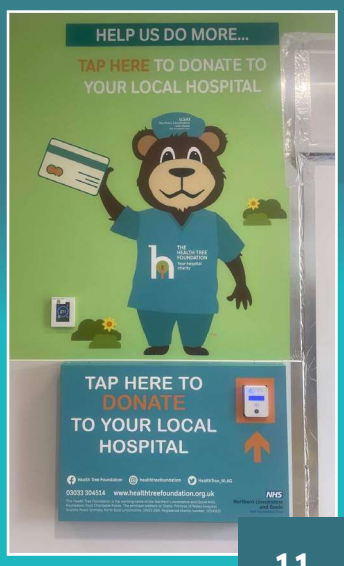
March

Our Tap to Donate in Scunthorpe General Hospital's A&E department went live!

Scunthorpe General Hospital

May

We have made donating to The Health Tree Foundation even easier with our contactless donation points!



Highlights of the year 2023

It was Coronation Day!

May

All sites

The Health Tree Foundation were so happy to provide wards with a pack of decorations to help celebrate this historical day with our patients.

A generous donation of £1,250!

May

Diana Princess of Wales Hospital, Grimsby

We would like to say a huge thank you to myenergi for their generous donation of £1,250 to the Neonatal Intensive Care Unit at Diana Princess of Wales Hospital in Grimsby. A cheque presentation was held at Blundell Park at one of the GTFC matches.

Thank you cards!

May

Scunthorpe General Hospital

We would like to say a heart-felt thank you to the pupils from St Bedes Academy, Scunthorpe for these wonderful cards they made for all the amazing nurses in recognition of International Nurses Day at Scunthorpe General Hospital.

May

Walking Challenge

Diana Princess of Wales Hospital, Grimsby

We would like to say a huge thank you and well done to Shaun who took part in a walking challenge to raise money to help patients recovering from Covid at Diana, Princess of Wales Hospital, Grimsby. Shaun raised over £800!

Look how much fun was had on the Disney Ward!

Scunthorpe General Hospital

May

Spiderman and Rapunzel made a visit to the ward to sing, pull funny faces and even joined in building Lego with the children.

On behalf of the Disney Ward, we would like to say a massive thank you to Little Enchantments for helping to put a smile on little faces.

Strandguide LTD Donation

June

Diana Princess of Wales Hospital, Grimsby

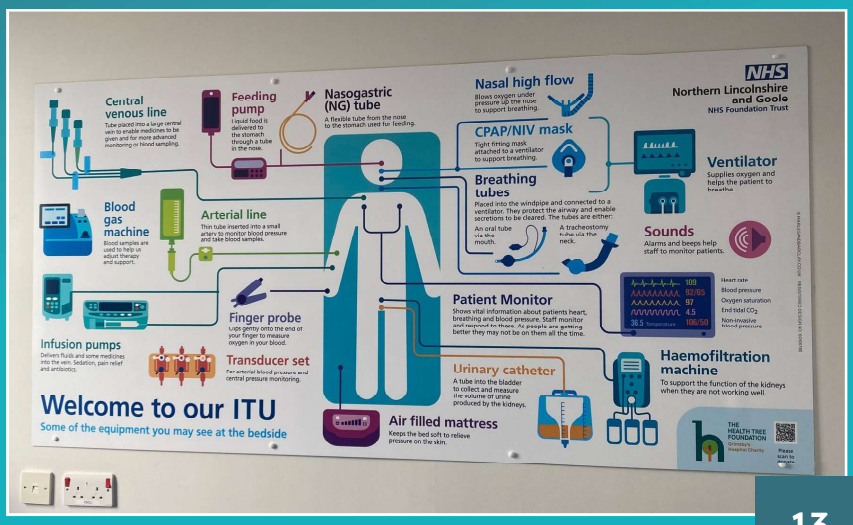
We would like to say a huge thank you to all at Strandguide LTD for their amazing efforts in raising money for the Amethyst Ward at Grimsby's Diana Princess of Wales Hospital. A cheque was presented for a fantastic £1,432.90! Your donation will make such a difference in improving patient experience on the Amethyst Ward.

Information Board

June

Diana Princess of Wales Hospital, Grimsby

We are delighted to share another brilliant wish which has been granted thanks to your generous donations.
A new relatives information board in ITU. This fantastic and informative board is designed to help relatives understand the purpose of different types of equipment used, helping reduce their anxiety and making their experience with Critical Care a more positive and understandable one whilst with loved ones.



Highlights of the year 2023

The Mayor of Grimsby

June

Diana Princess of Wales Hospital, Grimsby

Councillor Ian Lindley, who works in the Theatres at Grimsby's Diana Princess of Wales Hospital, as an Operating Department Practitioner, was recently elected Mayor. He chose The Pink Rose Suite as one of his charities to raise money for, through The Health Tree Foundation. The unit is close to his heart as his wife and Mayoress, Helen Lindley, works as an Advanced Nurse Practitioner. The couple also have a special connection with the unit.

Ian said: "I met my wife during a social event to raise money for the Pink Rose Suite in 2007, so it's great I'm now able to support the unit in this way. I will be doing various events throughout the year to raise funds, such as a Mayor's Ball and charity nights. "With us both working at the hospital and Helen working on the unit, it felt like a natural choice. The staff are fantastic and I see first-hand the terrific care patients receive."

Book donation

June

Diana Princess of Wales Hospital, Grimsby & Scunthorpe General Hospital

We would like to thank local author and NLAG staff member, Debbie Webb, for her very kind donation of her collection of books which she delivered to both children's wards at Grimsby's Diana Princess of Wales Hospital and Scunthorpe General Hospital. The children will love hearing about the adventures her little dog gets up to.
Thank you so much Debbie.

Welcome Jemma!

July

We are delighted to introduce you to Jemma Qualter who joined the Health Tree Foundation Team in July.

Jemma is our new Central Admin and Fundraising Support Trustwide. Jemma has worked in the local community of Scunthorpe in her previous role and is no stranger to the world of fundraising and charity support.

New uniforms for our volunteers

July

All sites

We are so grateful for our volunteers who give up their time to help support staff, patients and their families within the hospital. Thanks to your donations, we have been able to fund a new uniform to make it easier for patients and visitors to spot our amazing helpers. Next time you see them, be sure to give them a smile and a thank you.

Generous Donation!

July

Diana Princess of Wales Hospital, Grimsby

We would like to say a big thank you to Cllr Steve Beasant for his generous donation of £220.75 for our Little Lives Appeal for Grimsby's Diana Princess of Wales Hospital.

Waiting Room Makeover

August

Scunthorpe General Hospital

The waiting room in the Urology Department at Scunthorpe General Hospital has had a makeover. We have changed a tired seated area into a bright, inviting space for patients to feel relaxed while waiting to be seen. This was made possible thanks to donations from the community and the staff taking part in their own fundraising endeavours.

July

NHS Big Tea Party

All sites

This July we celebrated the NHS's 75th Birthday. Wards and departments across our Trust celebrated NHS Big Tea by hosting tea parties on their ward.

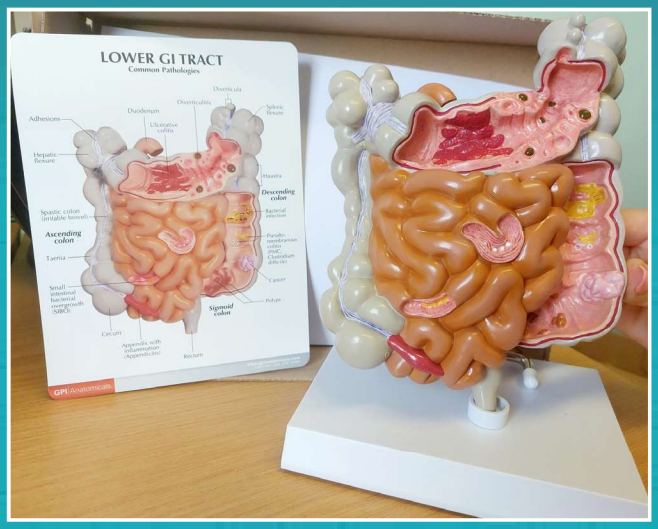
Highlights of the year 2023

GI Tract Model

August

Scunthorpe General Hospital

With your generous donations, we've been able to purchase a Lower GI Tract with Pathologies model for our Surgery and Critical Care Team at Scunthorpe General Hospital. This model will help educate our patients on the findings of their investigations when attending our outpatient's clinic to discuss their results



Colouring Books

August

All sites

We have funded our very own Scrubs Colouring books. These will be a great distraction to patients while visiting our hospitals for appointments and treatment.

Ashby Golf Club Donation!

September

Scunthorpe General Hospital

We would like to thank Ashby Decoy Golf Club for raising an amazing £2500 for Scunthorpe Stroke Unit, at their annual charity Golf Day!

Skydive

August

A massive well done to our very brave fundraisers, who took part in our Sky Dive event!

September

Westfield Alpacas

Scrubs met up with his new friend, Westfield Alpacas!

October

Mount Snowdon

Scunthorpe General Hospital

A huge well done to our team of staff who climbed Yr Wyddfa (Mount Snowdon). They are raising funds for equipment to benefit patients needing surgery. Despite the dreadful weather on the day, they still managed the climb and have raised more than £1,700!!

Tony's Charity Walk

Diana Princess of Wales Hospital, Grimsby

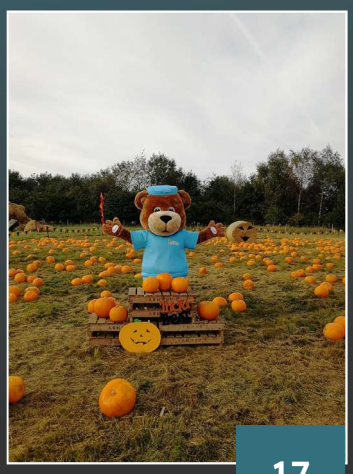
September

We want to say a huge well done to Tony for achieving his charity walk in Cleethorpes. Tony was supported and cheered on by such wonderful family and friends who were taking donations along the way. The Neuro Rehab Centre in Goole are truly grateful for your fundraising!

October

The Pink Pig Farm

Scrubs visited The Pink Pig Farm in Scunthorpe!



Highlights of the year 2023

Mount Snowdon

October

Scunthorpe General Hospital

Thank you to Emma and Lee Clay for yet another fabulous fundraising event!

Your Halloween party was enjoyed by all and a real success! And on top of this, your decorated spooky garden also added to your fundraising total.

Thank you for your continuing to support our Neonatal Intensive Care Unit at Scunthorpe General Hospital.

Charity Champion Award

November

Congratulations are in order for Sharon, on receiving The Health Tree Foundation Charity Champion Award at the Our Stars Event on Friday 24th November 2023.

Thank you for everything you are doing for the Children's Development Centre garden, your efforts do not go unnoticed!

NICU Library

October

Diana Princess of Wales Hospital, Grimsby

We funded a neonatal library on the Neontal Intensive Care Unit (NICU) at Diana, Princess of Wales Hospital, Grimsby. This will enable parents as well as siblings to read to their new baby while receiving care on the NICU. Reading supports early brain development and language skills as well as providing comfort for the baby through the sounds of familiar voices.

Thanks to your donations and continuing support we can make these wishes come true!

Jax's Fundraising

November

Diana Princess of Wales Hospital, Grimsby

In November, we met up with the amazing Jax and received a fabulous donation for the Rainforest Ward at Diana, Princess of Wales Hospital in Grimsby.

Jax and his team mates, took part in a sponsored walk at midnight from Cleethorpes Pier to Grimsby Hospital. With the money raised, they managed to purchase two PlayStation 5 consoles and games as well as donating an incredible £1000 too!

Thank you so much those of you who have supported Jax and his team mates, you're all Health Tree Heroes!

Scunthorpe Rugby Club Donation

November

Diana Princess of Wales Hospital, Grimsby

A huge thank you to the ladies at Scunthorpe Rugby Club, who raised £1000 for The Pink Rose Suite at Diana, Princess of Wales Hospital, Grimsby.

Grimsby Cars Event

December

Diana Princess of Wales Hospital, Grimsby

We were absolutely blown away with the final total from Grimsby Cars Ltd summer event!

A huge £11,000 was raised for the NICU ward at Diana, Princess of Wales Hospital, Grimsby.

Highlights of the year 2023

December

Santa Run

Diana Princess of Wales Hospital, Grimsby

We hosted Keelby Santa Run, and what a great day it was!

Christmas Gifts!

December

All sites

Over the Christmas period, we received so many kind and generous gifts for all the patients who spent Christmas in our hospitals. Thank you so much for all the kind donations and visits!

Highlights of the year 2024

Pauline Thompson Fundraising

January

Diana Princess of Wales Hospital, Grimsby

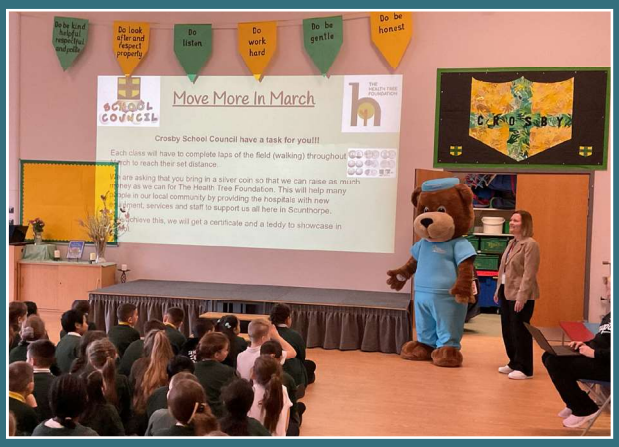
We are so pleased to annouce that our amazing fundrasier, Pauline Thompson, has reached a staggering £10,000 of donations. Pauline has been fundraising for The Pink Rose Suite for several years and has now reached this fantastic figure. Well done Pauline, your continued support means so much to us!

Crosby School

March

Scunthorpe General Hospital

In March, we visited Crosby School in Scunthorpe with our mascot Scrubs! The children are taking part in our 'Move More In March' campaign, raising money for our Little Lives Appeal. Each year group is walking laps around the field, which will total a fantastic 101.5km



Knitted Hearts

Scunthorpe General Hospital

We received a lovely donation of knitted hearts from Dunelm Scunthorpe's Knit and Stitch group. Thank you so much ladies - these are perfect for our Critical Care wards and end of life patients, who hold onto these in their last moments and give great comfort to their loved ones.

January

February

New Sky Lights

Diana Princess of Wales Hospital, Grimsby

The Health Tree Foundation recently funded these beautiful skylights in the new Same Day Emergency Care building at Diana, Princess of Wales Hospital, Grimsby. These make the area feel less clinical, and provide a brighter atmosphere, helping patients to feel more relaxed while they are receiving care.

Reborn Doll

February

Goole and District Hospital

Thank you to Joanne at Hey Credit Union, for the kind donation of a reborn doll, for dementia patients at Goole District Hospital. This will really make a difference to patients staying with us, thank you so much for your kindness.

NHS CHARITIES TOGETHER

We have received Community Grants of £152,000 from NHS Charities Together in 2022/23.

The Community Grants have been awarded to charities in the local community.

The Development Grant will be used to support Operations, Learning and Evaluation and Fund Raising allowing us to develop the Charity, improve our processes and create a new role of Digital Fundraising within our Charity.

Thank you NHS Charities Together!

The Circle of Wishes

The Circle of Wishes has been open to requests from staff and patients for items which would improve patient care within our hospitals.

We received 286 different wishes throughout the 23/24 period and invested £451,000 in granting wishes.

Health Tree Foundation invested £451,000 on wishes in 23/24.

Gift in Wills

Over the past few years, The Health Tree Foundation has benefited greatly from legacy gifts left in people's Wills.

In 2023/24 we received £248,000 in legacy income!

Choosing a charity to include in a Will is a very personal choice. You may have a connection with one of the hospitals we support or perhaps The Health Tree Foundation has helped you or a loved one in the past. Or you may simply wish to support your local NHS.

After providing for your loved ones, a gift to The Health Tree Foundation is another way of showing how much you care - because small or large, your gift will help to improve health and wellbeing for your family and everyone in Northern Lincolnshire and Goole.

Many of the gifts we receive are from people who want to 'give something back' to the hospitals out of gratitude for the care and support they may have received or to say thank you for the care of a loved one.

If you would like more information on how easy it is to support your local hospital charity through a gift in your Will or to learn more about the difference we have been able to make through generous donations, please contact us at **hello@healthtreefoundation.org.uk**

HTF Lottery

The Health Tree Foundation fundraising lottery has been a great success. Tickets are £1.00 each. A weekly draw with a jackpot of £1,000 and 80 prizes of £10 takes place each Friday. Raise funds for your local hospital charity via weekly draws and have the chance to win up to £10,000!

A review of our finances, achievements & performance

Public Benefit

As a Charity, our main purpose is to benefit the public. Our ambition is to transform donations of time and money into making the NHS sparkle for patients throughout our local community. We couldn't do this without donations, legacies and investment, which continue to be our main sources of income. Our total assets, income and expenditure for this financial year is set out in the next few pages.

Assets

To support The Health Tree Foundation's activities, the Charity continues to maintain a healthy cash balance and investment portfolio. The stock market continues to be volatile and changes within it have impacted the valuation of our investments, however these are reviewed on a regular basis by The Health Tree Foundation Trustees Committee to explore the potential for taking mitigating actions.

The Public Perception Test

When considering its use of funds, a person should ask him or herself; Would someone who puts a pound in a collecting bucket be happy for it to be spent this way? Would you be proud to tell a donor about this expenditure, and the difference it is making, or would you find yourself defending a purchase which you know should really come from your core budget?

Total Assets

2023/2024
1,423

2022/2023
1,412

Net Assets
Increase/(Decrease)

2023/2024
11

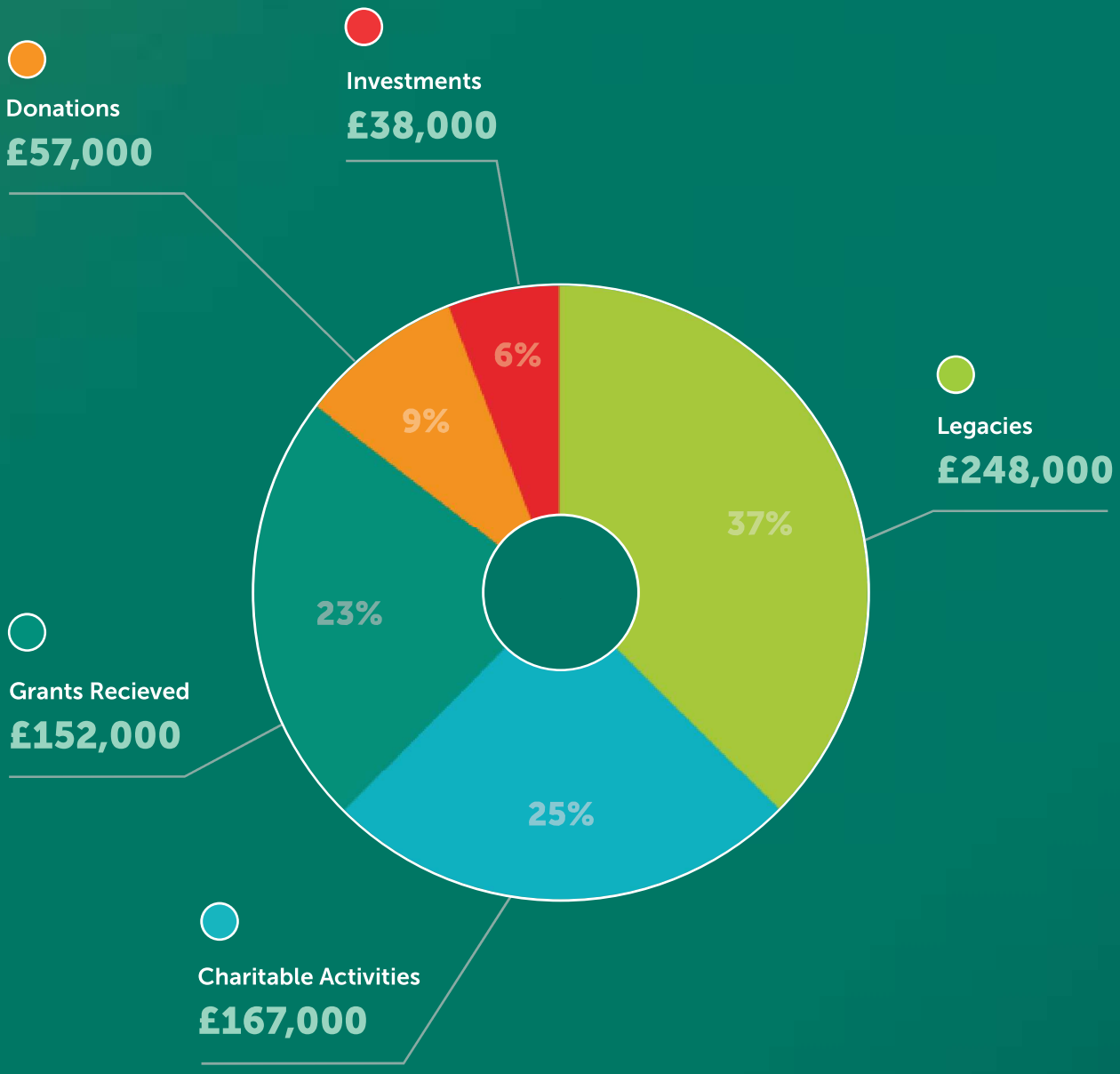
2022/2023
(598)

Valuation of Investments
Gain/(Loss)

2023/2024
114

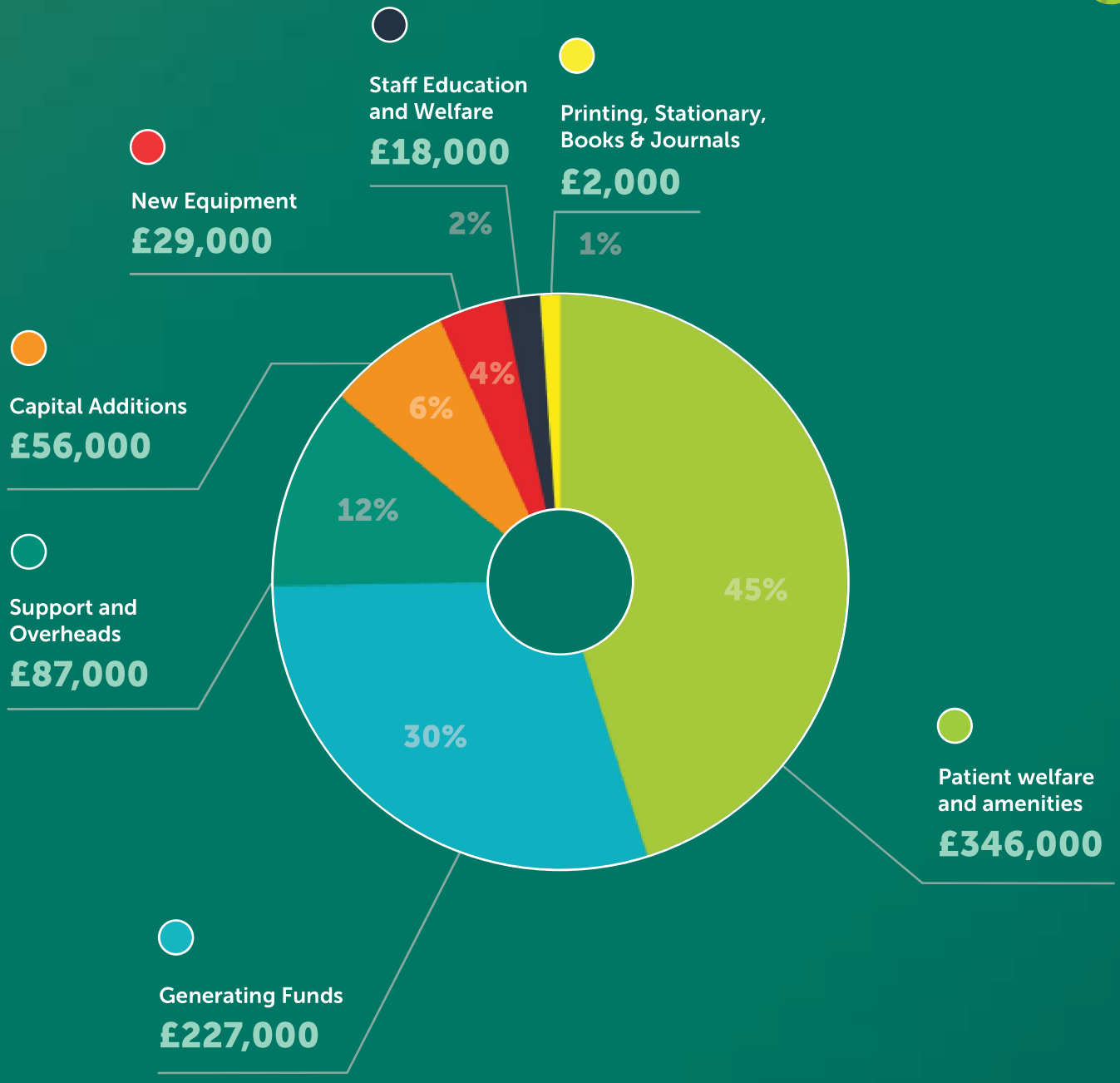
2022/2023
(89)

Income
2023/2024



Total Income:
£662,000

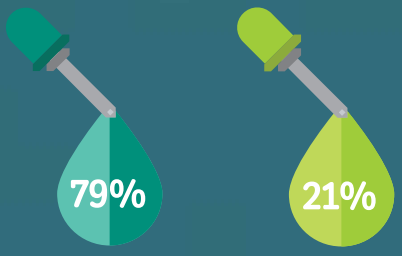
Expenditure
2023/2024



Total Expenditure:
£765,000

New Equipment

Buying new equipment represents a vital and valuable contribution to enhancing clinical and medical care across our region. Purchases range from small items costing a few pounds each, through to specialist diagnostic equipment costing several thousand pounds.



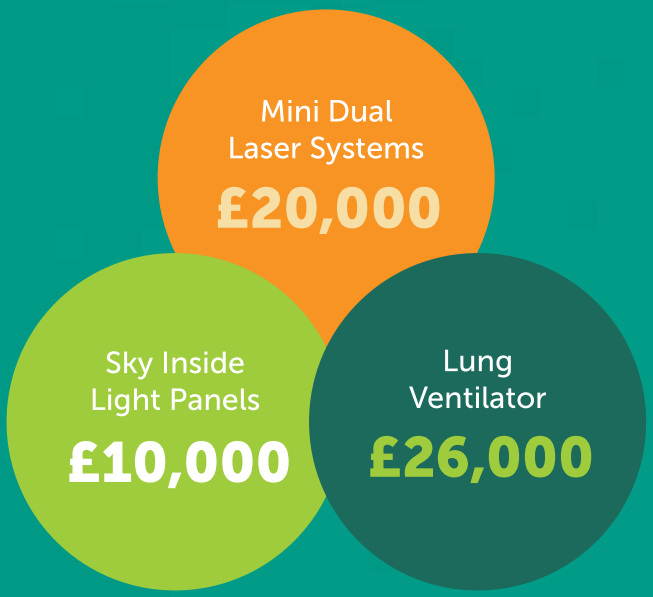
Medical equipment
£23,000

Other Equipment, including IT equipment
£6,000

Total: £29,000

Capital Additions

Capital additions reflect the money we spend on buying new assets, or improving existing ones, to further the quality of care that patients receive across our hospital sites.



Total: £56,000

Staff Education and Welfare

We're committed to delivering meaningful benefits to patients and their families. To do this, we need highly-skilled staff who can ensure we realise our ambitions. Training and developing our people is key to this, as is staff welfare.

Total: £18,000

Performance Management

The Health Tree Foundation does not have any direct employees. Fundraising and administration staff are seconded to the Charity from the Hull & East Yorkshire Smile Foundation, helping us keep costs down while providing the skills needed to make a real difference. These seconded employees manage our Charity, together with employees from the Northern Lincolnshire & Goole NHS Foundation Trust, ensuring we keep administration costs to a bare minimum.

Foundation Trust staff work closely with The Health Tree Foundation Trustees Committee (formerly known as Charitable Funds Committee) and the Equipment Group to identify priorities, assess the suitability of funding requests and make sure the money we spend makes a real difference to the communities we serve.

Reserves Policy & Investments

Reserves Policy Statement

The Trustees have updated the Charity's reserves policy following a review of the guidance set out by the Charity Commission, and the significant changes to Charities Statement of Recommended Practice (SORP) 2019.

The Trustees are under a legal duty to apply charitable funds in furtherance of charitable objectives within a reasonable time of receiving them. Under normal circumstances, a period of 12 months is considered reasonable; therefore the Charity would expect to hold reserves approximately equal to the running costs. This amounts to **£314,000** per year for fundraising staff costs, office costs and governance costs. The Trustees recommend that in addition to running costs, general expenditure costs for six months are maintained in reserves. Based on the 2023/2024 financial year, this would be **£226,000.** Therefore the minimum amount required to be held in reserves is **£540,000**.

The Trustees recognise that it may be necessary in the future to achieve the target level of reserves by retaining a portion of the income from investments. The Trustees consider it necessary to retain reserves over the longer term to:

- Minimise the risk should levels of donated income reduce significantly that the Charity cannot meet its obligations
- Hold sufficient reserves to ensure the Charity can cover its ongoing operational costs to process outstanding commitments.

The value of fixed asset investment goes down as well as up. Where values go down, funds need to be safeguarded from such losses through the level of reserves retained. The Trustees continue to review the balances held in all funds, in accordance with the provisions of the NHS Acts relating to charitable funds, to determine whether these are likely to be committed in the near future.

Investments

The corporate Trustee invests its charitable funds with CCLA Investment Management Ltd in their Charities Official Investment Funds (COIF). Dividends are paid directly into the Charity's bank account. As of 31 March 2024 96% (2022/2023; 89%) of non-liquid funds were invested in COIF.

As of 31 March 2024, the market value of investments were: COIF Ethical Investment Fund **£1,267k** (2022/2023 £1,383k)

The Health Tree Foundation Trustees Committee regularly reviews the level of investments and undertakes market testing to ensure the Charity has the correct balance between risk and returns, and maintains adequate liquidity.

During 2023/2024 the investments gained **£114,000** (2022/2023 loss of £89,000. The stock market continues to be volatile and the Health Tree Foundation Trustees Committee regularly reviews performance to explore the potential for mitigating action.

The Trust's ethical investment policy prevents investment in companies directly involved in the production of tobacco products, alcohol and arms.

The remaining balance of the liquid reserves are held in commercial bank accounts, which total **£50,000** (2022/2023 £170,000).

THE TRUSTEE GIVES THANKS

Northern Lincolnshire and Goole NHS Foundation Trust & Hull University Teaching Hospital NHS Trust is grateful to the many individuals, groups, associations, clubs and societies who have given generously of their time, money and bequests, to the Trust's Charitable Funds throughout the year.

On behalf of the staff and patients who have benefited from improved services and amenities they would like to express their thanks.

Approved on behalf of the Corporate Trustee

.....

Date:

Neil Gammon, Chair of Northern Lincolnshire and Goole NHS Foundation Trust Charitable Funds and Other Related Charities

.....

Date:

Jonathan Lofthouse, Group Chief Executive for Northern Lincolnshire & Goole NHS Foundation Trust and Hull University Teaching Hospital NHS Trust

Reference and Administrative Details

The Main Charity, Northern Lincolnshire & Goole NHS Foundation Trust Charitable Funds and Other Related Charities, registered Charity Number 1054935 was entered on the Central Register of Charities on the 26th April 1996.

The Charitable Trust Funds, as at 31st March 2024 is constituted of an 'Umbrella Fund', which covers a total of 45 funds (2022/2023 45).

The NHS Foundation Trust Board devolved responsibility for the on-going management of funds to the Health Tree Foundation Trustees' Committee (formerly Charitable Funds Committee) that administers the funds on behalf of the Corporate Trustee. The names of those people who serve as agents for the Corporate Trustee, as permitted under regulation 16 of the NHS Trusts (Membership and Procedures) Regulations 1990, is as follows as of 31st March 2024:

Mr N Gammon
Independent Chair of the Health Tree Foundation Trustees Committee, Northern Lincolnshire & Goole NHS Foundation Trust

Mr S Lyons
Chair, Northern Lincolnshire & Goole NHS Foundation Trust, Non-Executive Director

Mr JM Lofthouse
Group Chief Executive, Northern Lincolnshire & Goole NHS Foundation Trust (Appointed August 2023)

Dr P Reading
Chief Executive, Northern Lincolnshire & Goole NHS Foundation Trust (Resigned June 2023)

Mr L Bond
Group Chief Financial Officer, Northern Lincolnshire & Goole NHS Foundation Trust

Mr J Johal
Director of Estates & Facilities Management, Northern Lincolnshire & Goole NHS Foundation Trust (Resigned December 2023)

Ms SP Liburd
Non-Executive Director

Mrs E Monkhouse
Chief Nurse, Northern Lincolnshire & Goole NHS Foundation Trust (Resigned November 2023)

Dr K Wood
Group Chief Medical Officer, Northern Lincolnshire & Goole NHS Foundation Trust

Mr IP McConnell
Group Director Strategy and Partnership, Northern Lincolnshire & Goole NHS Foundation Trust (Appointed November 2023)

Mr S Hall
Associate Non-Executive Director, Northern Lincolnshire & Goole NHS Foundation Trust

Mrs L Jackson
Vice Chair & Non-Executive Director, Northern Lincolnshire & Goole NHS Foundation Trust

Mr S Nearney
Group Chief People Officer, Northern Lincolnshire & goole NHS Foundation Trust

Mrs F Osborne
Associate Non-Executive Director, Northern Lincolnshire & Goole NHS Foundation Trust (Resigned December 2023)

Mr S Parkes
Non-Executive Director, Northern Lincolnshire & Goole NHS Foundation Trust

Mrs G Ponder
Non-Executive Director, Northern Lincolnshire & Goole NHS Foundation Trust

Mrs K Truscott
Non-Executive Director

Mr P Marchant
Chief Financial Accountant, Northern Lincolnshire & Goole NHS Foundation Trust

Principle Charitable Fund Advisor to the Board

During 2023/24, the Chief Executive of the Northern Lincolnshire & Goole NHS Foundation Trust, under a scheme of delegated authority approved by the Corporate Trustee, has overall responsibility for the management of the Charitable Funds. Mr J Lofthouse was appointed Chief Executive in August 2023. Prior to this Dr Peter Reading was Chief Executive.

The arrangements for approval of charitable fund expenditure under the scheme of delegation of the Corporate Trustee are as follows:

Delegation Limits

£1 - £250
Authorisation from The Health Tree Foundation Charity Manager

£251 - £5,000
Further authorisation from Fund Guardian

£5,001 - £25,000
Further authorisation from Charitable Funds Clinical Champion

£25,001 - £50,000
Further authorisation from Charitable Funds Committee

£50,001 and above
To be noted by NHS Foundation Trust Board

Mr Paul Marchant acts as the Principal Officer overseeing the day-to-day financial management and accounting for the charitable funds during the year.

The Directors do not receive remuneration or expenses from the Charity.

Structure, Governance and Management

The Charity was incorporated on March 19th, 1996 by a declaration of trust deed, and all funds held on trust as at the date of registration were either part of the unrestricted funds, registered restricted funds or unregistered restricted funds.

The Corporate Trustee fulfils its legal duty by ensuring funds are spent in accordance with the objects of each fund. By designating funds, the Trustee respects the wishes of our generous donors to benefit patient care and advance the good health and welfare of patients, carers and staff. Where funds are received with specific restrictions set by the donor, the donation will be ringfenced for a specific area within the wider relevant fund – for example, Cardiology, Cancer Equipment, Ophthalmology, General Surgery, Urology, and for specific wards. The Board of Trustees manage the funds on behalf of the Corporate Trustee. The Board of Trustees consists of Executive and Non-Executive Directors. Non-Executive Directors are appointed by the Council of Governors and Executive Directors are subject to the Trust's recruitment policies.

Acting for the Corporate Trustee, The Health Tree Foundation Trustees' Committee is responsible for the overall management of the Charitable Funds. The Committee is required to:

- Provide support, guidance and encouragement for all its income-raising activities whilst managing and monitoring the receipt of all income.
- Control, manage and monitor the use of the fund's resources.
- Ensure best practice is followed in the conduct of all its affairs and fulfil all its legal responsibilities.
- Adhere to the Investment Policy, as approved by the Foundation Trust Board, and ensure performance is continually reviewed whilst being aware of ethical considerations.
- Keep the Trust Board fully informed on the activity, performance and risks of the charity.

The accounting records and the day-to-day administration of the funds are dealt with by the Finance Department's Charitable Funds section at Eastholme Building, Diana, Princess of Wales Hospital, Scartho Road, Grimsby, North East Lincolnshire, DN33 2BA.

The fundraising, grant-making and other administration of funds are dealt with by The Health Tree Foundation, which has staff at Diana, Princess of Wales Hospital, Scartho Road, Grimsby, North East Lincolnshire, DN33 2BA, and Scunthorpe General Hospital, Cliff Gardens, Scunthorpe, North Lincolnshire, DN15 7BH.

Our Future Plans

The aims and objectives for the next twelve months are to continue to work to deliver on our three-year strategy. The strategy is framed around five key workstreams:

- Income generation to support a three-year Fundraising and Operations Delivery Plan.
- Internal relationships, awareness, and impact maximisation
- External communications, marketing, and community positioning
- Improved working with fund guardians
- Effective systems, processes, and governance

In addition to the workstreams, three key priority areas have been identified for 2023/24 as follows:

- Build a network of fundraisers and supporters
- Greater engagement with clinical teams and trust staff.
- Maximizing potential funds
- Our charitable expenditure will continue to be determined by the equipping needs of the hospital and may include the following areas of spend:
- Purchase of Medical equipment
- Enhancement of patient facilities
- Staff training, conferences, and educational resources
- Support of research projects

Based on the Accounts for the financial year the Trust Board, on behalf of the Corporate Trustee, believes that the Charity can meet all their current and future foreseeable commitments.

Risk Management

The Corporate Trustee is responsible for managing risk issues for the Charity, which is underpinned by the internal policies and procedures of the NHS Foundation Trust, including:

- Code of Conduct
- Standing Orders
- Fraud Policy
- Standing Financial Instructions and Scheme of Delegation

Statement of Trustees' Responsibilities

The Trustee is responsible for preparing the Trustees' Annual Report and the financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice).

The law applicable to charities in England and Wales requires the Trustee to prepare financial statements for each financial year, which give a true and fair view of the state of affairs of the Charity and of the incoming resources and application of resources of the Charity for that period.

In preparing these financial statements, the Trustee is required to:

- Select suitable accounting policies and then apply them consistently.
- Observe the methods and principles in the Charities SORP
- Make judgments and estimates that are reasonable and prudent.
- State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements.
- Prepare the financial statements on the going concern basis unless it is inappropriate to presume that the Charity will continue in business.

The Trustee is responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the Charity and enable them to ensure that the financial statements comply with the Charities Act 2011, the Charity (Accounts and Reports) Regulations 2008 and the provisions of the trust deed.

They are also responsible for safeguarding the assets of the Charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Trustee is responsible for the maintenance and integrity of the Charity and financial information included on the Charity's website. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Northern Lincolnshire and Goole NHS Foundation Trust is grateful to the many individuals, groups, associations, clubs and societies who have given generously of their time, money and bequests, to the Trust's Charitable Funds throughout the year. On behalf of the staff and patients who have benefited from improved services and amenities they would like to express their thanks.

Approved on behalf of the Corporate Trustee

.....

Date:

Neil Gammon, Chair of Northern Lincolnshire and Goole NHS Foundation Trust Charitable Funds and Other Related Charities

.....

Date:

Jonathan Lofthouse, Group Chief Executive for Northern Lincolnshire & Goole NHS Foundation Trust and Hull University Teaching Hospital NHS Trust

Independent Auditor's Report

Independent auditor's report to the Trustees of Northern Lincolnshire and Goole NHS Foundation Trust Charitable Funds and Other Related Charities.

Opinion on financial statements

We have audited the financial statements of Northern Lincolnshire and Goole NHS Foundation Trust Charitable Funds and Other Related Charities (the 'charity') for the year ended 31 March 2023 which comprise Statement of Financial Activities, the Balance Sheet, the Statement of Cash Flows, and notes to the financial statements, including a summary of significant accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including FRS 102 "The Financial Reporting Standard applicable in the UK and Republic of Ireland" (United Kingdom Generally Accepted Accounting Practice).

In our opinion, the financial statements:

- give a true and fair view of the state of the charity's affairs as at 31 March 2023 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the requirements of the Charities Act 2011.

Basis for opinion on financial statements

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the "Auditor's responsibilities for the audit of the financial statements" section of our report. We are independent of the charity in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the trustees' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the charity's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the trustees with respect to going concern are described in the relevant sections of this report.

Other information

The trustees are responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Independent Auditor's Report

Matters on which we are required to report by exception

In light of the knowledge and understanding of the charity and its environment obtained in the course of the audit, we have not identified material misstatements in the Annual Report.

We have nothing to report in respect of the following matters in relation to which the Charities (Accounts and Reports) Regulations 2008 require us to report to you if, in our opinion:

- the information given in the financial statements is inconsistent in any material respect with the Annual Report; or
- sufficient accounting records have not been kept; or
- the financial statements are not in agreement with the accounting records; or
- we have not received all the information and explanations we require for our audit.

Responsibilities of Trustees

As explained more fully in the Statement of Trustees' Responsibilities set out on page 30, the Trustees are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the trustees determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the trustees are responsible for assessing the charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the trustees either intend to liquidate the charity or to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below.

Irregularities, including fraud, are instances of noncompliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Based on our understanding of the charity and its industry, we considered that non-compliance with the following laws and regulations might have a material effect on the financial statements: employment regulation, health and safety regulation, and anti-money laundering regulation.

Independent Auditor's Report

To help us identify instances of non-compliance with these laws and regulations, and in identifying and assessing the risks of material misstatement in respect to non-compliance, our procedures included, but were not limited to:

- Inquiring of management and, where appropriate, those charged with governance, as to whether the charity is in compliance with laws and regulations, and discussing their policies and procedures regarding compliance with laws and regulations;
- Inspecting correspondence, if any, with relevant licensing or regulatory authorities;
- Communicating identified laws and regulations to the engagement team and remaining alert to any indications of non-compliance throughout our audit; and
- Considering the risk of acts by the charity which were contrary to applicable laws and regulations, including fraud.

We also considered those laws and regulations that have a direct effect on the preparation of the financial statements, such as the Charities Act 2011.

In addition, we evaluated the trustees' and management's incentives and opportunities for fraudulent manipulation of the financial statements, including the risk of management override of controls, and determined that the principal risks related to posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates, in particular in relation to revenue recognition (which we pinpointed to the cut off assertion, use of restricted funds, and significant one-off or unusual transactions).

Our audit procedures in relation to fraud included but were not limited to:

- Making enquiries of the trustees and management on whether they had knowledge of any actual, suspected or alleged fraud;
- Gaining an understanding of the internal controls established to mitigate risks related to fraud; Discussing amongst the engagement team the risks of fraud; and
- Addressing the risks of fraud through management override of controls by performing journal entry testing.

There are inherent limitations in the audit procedures performed and the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely we are to become aware of it.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Use of the audit report

We have been appointed as auditor under section 144 of the Charities Act 2011 and report in accordance with the Act and regulations made or having effect thereunder. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and

International Standards on Auditing (UK). Those standards require us to comply with the Financial Reporting Council's Ethical Standard. Our audit work has been undertaken so that we might state to the charity's trustees those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charity and the charity' trustees as a body for our audit work, for this report, or for the opinions we have formed.

Signed:

.....

Date:

Brian Clerkin

Senior Statutory Auditor
For and on behalf of ASM (B) Ltd
Chartered Accountants & Statutory Auditors
4th Floor Glendinning House
6 Murray Street
Belfast
BT1 6DN

Financial Statements

Northern Lincolnshire & Goole NHS Foundation Trust Charitable Funds and Other Related Charities 2023/24 Financial Statements.

Statement of Financial Activities for year ended 31 March 2024

	NOTES	UNRESTRICTED FUNDS £000	RESTRICTED FUNDS £000	TOTAL 2023/24 £000	TOTAL 2022/23 £000
Income from:					
Donation	3.1	57	0	**57**	59
Legacies	3.1	248	0	**248**	141
Grants received	3.1	152	0	**152**	502
Charitable activities	3.2	167	0	**167**	152
Investments	3.3	38	0	**38**	50
Total Income		**662**	0	**662**	**904**
Expenditure on:					
Raising funds	4.1	227	0	**227**	200
Charitable activities	4.2	451	0	**451**	1,155
Governance	4.3	87	0	**87**	58
Total Expenditure		**765**	0	**765**	**1,413**
Net gains / (losses) on investments	6.1	114	0	**114**	(89)
Net movement in funds		**11**	0	**11**	**(598)**
Reconciliation of funds:					
Total funds brought forward		1,412	0	1,412	
Net movement in funds		11	0	11	
Total funds carried forward	**9.1**	**1,423**	**0**	**1,423**	

The notes on pages 41 to 51 form part of these financial statements.

All results from continuing operations.

All gains and losses recognised in the year are included in the Statement of Financial Activities.

There is no material difference between the net outgoing resources on ordinary activities and the net outgoing resources for the financial year stated above and their historical cost equivalents.

Financial Statements

Northern Lincolnshire & Goole NHS Foundation Trust Charitable Funds and Other Related Charities 2023/24 Financial Statements.

Balance sheet for year ended 31 March 2024

	NOTES	UNRESTRICTED FUNDS £000	RESTRICTED FUNDS £000	31 MARCH 2024 TOTAL FUNDS £000	31 MARCH 2023 TOTAL FUNDS £000
Fixed assets:					
Investments	6.1	1,297	0	1,297	1,383
Total fixed assets	6.2	**1,297**	0	**1,297**	**1,383**
Current assets					
Debtors	7.1	116	0	116	48
Cash at bank and in hand	7.2	50	0	50	170
Total current assets	7	**166**	**0**	**166**	**218**
Creditors: Amounts falling due within one year	8	40	0	40	189
Current assets		**126**	0	**126**	**29**
Total net assets		**1,423**	0	**1,423**	1,412
Net assets		**1,423**	0	**1,423**	1,412
The Funds of the Charity:					
Restricted funds	9.2	0	0	**0**	0
Unrestricted funds	9.3	1,423	0	**1,423**	**1,412**
Total charity funds	9.1 , 9.4	**1,423**	0	**1,423**	**1,412**

The notes on pages 38 to 51 form part of these financial statements.

The financial statements on pages 34 to 47 were approved by the Board of Trustees and signed on its behalf by.

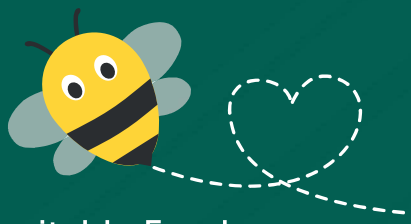
Signed:..... Date:

Mr Neil Gammon,

Chair of Northern Lincolnshire & Goole NHS Foundation

Trust Charitable Funds and Other Related Charities

Financial Statements



Northern Lincolnshire & Goole NHS Foundation Trust Charitable Funds and Other Related Charities 2023/24 Financial Statements.

Statement of Cash Flows for year ended 31 March 2024

	NOTES	TOTAL 2023/24 £000	TOTAL 2022/23 £000
Cash flows from operating activities			
Operating (deficit) / surplus from continuing operations		(141)	(559)
Operating (deficit) / surplus		**(141)**	**(559)**
Non-cash income and expense:			
(Increase) / decrease in Trade and Other Receivables		(68)	(18)
(Decrease) / Increase in Trade and Other Payables		(149)	151
NET CASH (USED) / GENERATED FROM OPERATIONS		**(358)**	**(426)**
Cash flows from investing activities			
Sales of financial assets		200	300
Interest received		38	50
Net cash generated from investing activities		**238**	**350**
(Decrease) / increase in cash and cash equivalents		(120)	(76)
Cash and Cash equivalents at 1 April 2023		170	246
Cash and Cash equivalents at 31 March 2024		**50**	**170**

Financial Statements

Northern Lincolnshire & Goole NHS Foundation Trust Charitable Funds and Other Related Charities 2023/24 Financial Statements.

Notes to Financial Statements

General Information

The Northern Lincolnshire & Goole NHS Foundation Trust Charitable Funds and Other Related Charities is charity registered with the Charity Commission for England and Wales. The working name of the Charity is the Health Tree Foundation. The Charity is incorporated in England.

Statement of compliance

The individual financial statements of Northern Linconshire and Goole NHS Foundation Trust Charitable Funds and other Related Charities have been prepared in compliance with United Kingdom Accounting Standards, including Financial Reporting Standard 102, "The Financial Reporting Standard applicable in the United Kingdom and the Republic of Ireland" ("FRS 102") and part vi of the Charities Act 2011 and the Charities (Accounts and Reports) regulations 2008.

1 Accounting Policies

1.1 Basis of Preparation

The financial statements have been prepared under the historic cost convention and going concern basis, with the exception of investments which are included at market value. The financial statements have been prepared in accordance with Accounting and Reporting by Charities: Statement of Recommended Practice (FRS102) issued in September 2015 and applicable UK Accounting Standards and the Charities Act 2011. The accounting policies have been applied consistently in dealing with items considered material in relation to the financial statements.

The principal accounting policies applied in the preparation of these financial statements are set out below. These policies have been consistently applied to all the years presented, unless otherwise stated. The company has adopted FRS 102 in these financial statements. The date of transition to FRS 102 was 1 April 2014. A reconciliation of the loss for the financial year ended 31 March 2015 and the total equity at 1 April 2014 and 31 March 2015 between UK GAAP as previously reported and FRS 102 is not required, as there are no changes in the reported amounts.

The Charity has taken advantage of the exemption, under FRS 102 paragraphs 11.39 to 11.48A and paragraphs 12.26 to 12.29, the requirement to disclose financial instruments, as the information is already provided in the consolidated financial statements of Northern Lincolnshire and Goole NHS Foundation Trust.

1.2 Funds Structure

Restricted funds are funds which are to be used in accordance with specific restrictions imposed by the donor. Where the restriction requires the gift to be invested to produce income but the trustees have the power to spend the capital, it is classed as expendable endowment.

Unrestricted income funds comprise those funds which the Trustee is free to use for any purpose in furtherance of the charitable objects. Unrestricted funds include designated funds, where the donor has made known their non-binding wishes or where the trustees, at their discretion, have created a fund for a specific purpose.

The charity does not have any expendable endowments.

The major funds held in each of the above categories are disclosed in note 9.

1.3 Incoming Resources

All incoming resources are recognised once the charity has entitlement to the resources. Provided it is probable that the resources will be received and the monetary value of incoming resources can be measured with sufficient reliability.

1.4 Incoming Resources from Legacies

Legacies are accounted for as incoming resources either upon receipt or where the receipt of the legacy is probable; this will be once confirmation has been received from the representatives of the estate(s) that payment of the legacy will be made or property transferred and once all conditions attached to the legacy have been fulfilled.

A receipt is normally probable when;

- there has been grant of probate;
- the executors have established that there are sufficient assets in the estate, after settling any liabilities, to pay the legacy; and
- any conditions attached to the legacy are either within the control of the charity or have been met.

Legacies to which the charity is entitled and for which notification has been received but uncertainty over measurement remains, are disclosed, if material, as contingent income.

1.5 Gifts in Kind

Assets given for distribution by the funds are included in the Statement of Financial Activities only when distributed.

In all cases the amount at which the gifts in kind are brought into account is either a reasonable estimate of their value to the funds or the amount actually realised.

1.6 VAT and Tax

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

The Charity is a registered charity, and as such is entitled to certain tax exemptions on income and profits from investments, and surpluses on any trading activities carried on in furtherance of the charity's primary objectives, if these profits and surpluses are applied solely for charitable purposes.

1.7 Allocation of Overhead and Support Costs

Overhead and support costs have been apportioned on an appropriate basis between all funds and are included within governance costs on the Statement of Financial Activities. The apportionment is in proportion to the quarterly aggregate balance on each of the funds or the fund incoming resources and is distributed on a quarterly basis.

1.8 Charitable Activities

Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objects of the charity. These costs comprise direct costs and an apportionment of overhead and support costs.

Liabilities are recognised when an order is placed and is monitored against the fund as a commitment. Once an invoice, goods or services are received then an accrual or a payment is shown in the financial statements.

1.9 Governance Costs

Governance costs comprise all costs incurred in the governance of the Charity. These costs include costs related to statutory audit together with an apportionment of overhead and support costs.

1.10 Fixed Asset Investment

Investments are stated at market value as at the balance sheet date. The statement of financial activities includes the net gains and losses arising on revaluation and disposals throughout the year.

The Common Investment Fund Units are included in the balance sheet at the closing dealing price at 31st March 2024.

1.11 Financial Instruments

The Charity has financial assets and financial liabilities of a kind that qualify as basic financial instruments. Basic financial instruments are initially recognised at transaction value and subsequently measured at their settlement value. The investments held by the charity are classified as financial assets measured at fair value through income and expenditure.

1.12 Realised Gains & Losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (purchase date if later). Unrealised gains and losses are calculated as the difference between the market value at the year end and opening market value (or purchase date if later).

1.13 Pooled Investments

An official pooling scheme the ***"Northern Lincolnshire and Goole NHS Foundation Trust (Expendable Funds) Common Investment Fund"*** is operated for investments relating to the following funds:

- Northern Lincolnshire & Goole NHS Foundation Trust Charitable Funds
- Scunthorpe General Hospital Charity
- Goole & District Hospital Charity
- Diana Princess of Wales Hospital Charity

The Scheme was registered with the Charity Commission on 26th August 1997.

2 Related Party Transactions

The Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) is the sole beneficiaries of the Charity.

The Charity has provided funding to NLAG of £765k (2022/23; £1,413k) for approved expenditure made on behalf of the charity. This funding is included in the total grant making costs of £765k (2022/23; £1,413k).

The Charity has incurred administration fees of £87k (2022/23; £58k) payable to the NLAG

Amounts due to NLAG at 31st March 2024 £7k (2022/23; £96k).

2.1 Ultimate Parent

NLAG is the immediate and ultimate parent undertaking and controlling party. It's principal activity is the provision of Heathcare and it prepares fully consolidated statements which are available at the following wbesite: www.nhs.nlg

NLAG is the Corporate Trustee of the Charity.

2.2 Role of volunteers

The Charity enlists the support of volunteers to achieve its objectives. The volunteers primarily assist in fundraising activities.

3 Analysis of Income Excluding Investment Income

3.1 Incoming resources from General Funds

	UNRESTRICTED FUNDS £000	RESTRICTED FUNDS £000	2023/24 TOTAL FUNDS £000	2022/23 TOTAL FUNDS £000
Donations from individuals & organisations	57	0	57	59
Legacies	248	0	248	141
* Grants Received From NHS Charities Together	152	0	**152**	**502**
Total	**457**	-	**457**	**702**

* Community Grants £ Nil (2022/23 £ 472,000) and Development Grants Received £ Nil (2022/23 £30,000) from NHS Charities Together

3.2 Incoming resources from Charitable Activities

	UNRESTRICTED FUNDS £000	RESTRICTED FUNDS £000	2023/24 TOTAL FUNDS £000	2022/23 TOTAL FUNDS £000
Fundraising	167	0	167	152
Total	**167**	**0**	**167**	152

3.3 Investment Income

	UNRESTRICTED FUNDS £000	RESTRICTED FUNDS £000	2023/24 TOTAL FUNDS £000	2022/23 TOTAL FUNDS £000
Investments in a Common Investment Fund	**38**	0	**38**	**50**
Total	**38**	0	**38**	**50**
All investments were held within the UK				
Total Income	**662**	-	**662**	**904**

4. Expenditure

4.1 Expenditure on Raising Funds

	UNRESTRICTED FUNDS £000	RESTRICTED FUNDS £000	2023/24 TOTAL FUNDS £000	2022/23 TOTAL FUNDS £000
Charges for seconded staff	180	0	180	159
Other fund raising expenses	47	0	47	41
Total: Fund Raising Expenditure	**227**	0	**227**	**200**

4.2 Total Charitable Activities

	UNRESTRICTED FUNDS £000	RESTRICTED FUNDS £000	2023/24 TOTAL FUNDS £000	2022/23 TOTAL FUNDS £000
Patients Welfare and Amenities	346	0	346	768
Medical Equipment	23	0	23	40
Other Equipment including IT	6	0	6	21
Staff Other Equipment	0	0	0	0
Equipment Supplied by partner charities	0	0	0	0
Printing, Stationery, Books and Journals	2	0	2	1
Staff Welfare & Amenities	9	0	9	71
Staff Furniture & Fittings	3	0	3	1
*Training & Education including Educational Aids	6	0	6	7
*Travel and Subsistence	0	0	0	1
Capital Equipment Purchased	**56**	0	**56**	245
Total: Charitable Expenditure	**451**	0	**451**	**1,155**

* Grants to individuals to attend training courses amounted to £ Nil (2022/23: £ Nil)

4.3 Governance Costs

	UNRESTRICTED FUNDS £000	RESTRICTED FUNDS £000	2023/24 TOTAL FUNDS £000	2022/23 TOTAL FUNDS £000
External Audit - audit fees	25	0	25	6
Financial Services Charges and Overheads	62	0	62	52
Total	**87**	0	**87**	**58**

Financial Services Charges and Overheads includes salary costs of £40 (2022/23 £40k) related to staff resources and £5k (2022/23 £5k) related to system charges bought in from the Northern Lincolnshire and Goole NHS Foundation Trust. The external audit fee accounted for within the financial statements includes £9k relating to the prior year. The final agreed external audit fee for 2023/24 is £12,300 (excluidng VAT).

4.4 Total resources expended

	2023/24 £000	2022/23 £000
Grants to Northern Lincolnshire and Goole NHS Foundation Trust	**765**	**1,413**
Total	**765**	**1,413**

4.4 Employee Costs & Numbers

The Charity does not have any employees (2022/23; nil)

Charges in relation to NHS Foundation Trust staff regarding their time spent on Charitable Funds finance and administration are included within governance costs, see note 4.2.

During the year the fund raising team were seconded to Charitable Funds from the Smile Foundation.

The costs of this secondment are included within the costs of generating voluntary income. These costs are apportioned to individual funds in proportion to the income raised.

The trustee does not receive remuneration or expenses from the Charity, (2022/23; nil)

5 Transfers

During the year there were no transfers from unrestricted funds into restricted funds (2022/23: none)

6 Investments

6.1 Movement in Fixed Asset Investment

	UNRESTRICTED FUNDS £000	RESTRICTED FUNDS £000	2023/24 TOTAL FUNDS £000	2022/23 TOTAL FUNDS £000
Market Value at 1 April	1,383	0	**1,383**	1,772
Add: Purchases at carrying value	0	0	**0**	0
Less: Disposals at carrying value	(200)	0	**(200)**	(300)
Add: Net gain / (loss)	114	0	**114**	(89)
Reclassification	0	0	**0**	0
Total: Market Value at 31 March	**1,297**	0	**1,297**	**1,383**

6.2 Fixed Asset Investments:

Investment

	Held in UK £000	2023/24 TOTAL FUNDS £000	2022/23 TOTAL FUNDS £000
Investment Fund and Fixed Interest Fund	1,297	**1,297**	1,383
Total: Market Value	**1,297**	**1,297**	1,383
Investments in a Common Investment Fund		1,297	1,383
Total: Market Value		**1,297**	**1,383**
All investments were held within the UK			

7 Analysis of Current Assets

7.1 Debtors Under 1 Year

	UNRESTRICTED FUNDS £000	RESTRICTED FUNDS £000	31 March 2024 TOTAL FUNDS £000	31 March 2023 TOTAL FUNDS £000
Trade Debtors	9	0	**9**	10
Prepayments	4	0	**4**	3
Other Debtors	103	0	**103**	35
Total: Debtors < 1 Year	**116**	0	**116**	**48**

7.2 Cash at bank and in hand

	UNRESTRICTED FUNDS £000	RESTRICTED FUNDS £000	31 March 2024 TOTAL FUNDS £000	31 March 2023 TOTAL FUNDS £000
Cash at bank and in hand	50	0	**50**	170
Total: Cash at bank and in hand	**50**	**0**	**50**	170
All short term investments and deposits are held in the UK with commercial banks and the Charities Official Investment Funds (COIF)				
Total of Current Assets	**166**	**0**	**166**	218

8 Creditors: Amounts falling due within one year

	UNRESTRICTED FUNDS £000	RESTRICTED FUNDS £000	31 March 2024 TOTAL FUNDS £000	31 March 2023 TOTAL FUNDS £000
Trade Creditors	16	0	**16**	68
Amounts owed to group undertakings	7	0	**7**	96
Accruals and deferred income	17	0	**17**	25
Total: Creditors: amounts falling due within one year	**40**	0	**40**	**189**

Amounts owed to group undertakings represents sums owed at the year end by the Charity to Northern Lincolnshire and Goole NHS Foundation Trust, who is a related party, for costs incurred by the NHS Foundation Trust on behalf of the charity, in the furtherance of the charity's objects.

Purchase Commitments

Orders raised at the Balance Sheet Date, for which goods have not been received amounted to £146k (2022/23; £43k).

9 Analysis of Charitable Funds

9.1 Charitable Fund Balances

	UNRESTRICTED FUNDS £000	RESTRICTED FUNDS £000	31 March 2024 TOTAL FUNDS £000	31 March 2023 TOTAL FUNDS £000
Total Charity Funds	**1,423**	**0**	**1,423**	1,412

9.2 Unrestricted Income Funds

	Fund Balance as at 01.04.23 £000	Incoming Resources £000	Expended Resources £000	Funds Transferred £000	Gains and Losses Inv. £000	Fund Balance as at 31.3.24 £000
Unrestricted Funds	206	201	(250)	0	14	171
Unrestricted Designated Funds (See Note 9.6)	1,206	461	(515)	0	100	1,252
Total General & Designated Funds	**1,412**	**662**	**(765)**	**0**	**114**	**1,423**

9.3 Total charity funds

	Fund Balance as at 01.04.23 £000	Incoming Resources £000	Expended Resources £000	Funds Transferred £000	Gains and Losses Inv. £000	Fund Balance as at 31.3.24 £000
Total General & Designated Funds	**1,412**	**662**	**(765)**	**0**	**114**	**1,423**

9.4 Analysis of designated fund movements

	Fund Balance as at 01.04.22 £000	Incoming Resources £000	Expended Resources £000	Funds Transferred £000	Gains and Losses Inv. £000	Fund Balance as at 31.3.23 £000
Big Thank You Appeal - Diana Princess of Wales Hospital	7	14	(21)	0	0	0
Big Thank You Appeal - Goole District Hospital	18	140	(58)	0	9	109
Big Thank You Appeal - Scunthorpe General Hospital	227	10	(76)	0	14	175
A&E	1	18	(15)	0	0	4
Big Red Heart	78	18	(18)	0	7	85
Cancer Care - General	423	24	(107)	0	31	371
Cancer Care - Pink Rose	31	32	(31)	0	3	35
Critical Care	12	9	(8)	0	1	14
Diabetes	46	3	(13)	0	3	39
End of Life Care	7	5	(3)	0	0	9
Goldern Leaves	42	3	(8)	0	4	41
In Your Community	33	24	(21)	0	3	39
Little Lives	0	102	(61)	0	3	44
Little Lives Bereavement	11	0	(3)	0	1	9
Medical	1	12	(4)	0	0	9
Research & Diagnostics	32	2	(3)	0	2	33
Rheumatology	48	1	(5)	0	4	48
Stroke	20	5	(5)	0	2	22
Surgery	169	39	(55)	0	13	166
Total General & Designated Funds	**1,206**	**461**	**(515)**	**0**	**100**	**1,252**

The Trustees set an opening or closing balance of £100,000 or above as the threshold for the separate reporting of material designated funds.

In the interests of accountability and transparency a complete breakdown of all such funds is available of request.

The objects of all these funds is for the welfare and benefit of staff and patients in the relevant wards and clinical areas.

10 Reconciliation of net income/(expenditure) to net cash flow from operating activities

	TOTAL 2023/24 £000	TOTAL 2022/23 £000
Net income/(expenditure) for the reporting period (as per the statement of financial activities)	11	(598)
(Gains)/Losses on investments	(114)	89
Dividends and interest from investments	(38)	(50)
(Increase)/decrease in debtors	(68)	(18)
Increase/(decrease) in creditors	(149)	151
Net cash used in operating activities	**(358)**	**(426)**

A big THANK YOU!

"The Health Ttee Team have provided just what our department needed to give out patients the privacy they require while in our waiting area and the outside of the hopsital now looks much more improved.

Many thanks to Lauren Henry and all involved in making such a big positive change for our department

The wish was to improve the comfort of the patients while sitting for long periods in the counselling room after receiving a cancer diagnosis.

Many senior patients require furniture that is easy to sit in and rise from, the furniture needs to be the right seat Hight, the contemporary furniture offers this. and therefore comfort.

The material and color , brings a softness, enhancing the athletics to the counselling room."

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)176

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	8 August 2024
Director Lead	Simon Parkes & Jane Hawkard – Non-Executive Directors / Chairs of Audit, Risk and Governance Committees-in-Common Tony Curry – Non-Executive Director / Acting Chair of the June 2024 HUTH Audit, Risk and Governance Committee meeting.
Contact Officer / Author	Simon Parkes / Jane Hawkard / Tony Curry
Title of Report	**Audit, Risk and Governance Committees-in-Common Minutes – April 2024 & HUTH Audit, Risk and Governance Committee – June 2024**
Executive Summary	Minutes of the Audit, Risk and Governance Committees-in-Common (ARG CiC) meeting held on 25 April 2024, approved at the ARG CiC meeting on 25 July 2024. Minutes of the Hull University Teaching Hospitals NHS Trust (HUTH) Audit, Risk and Governance Committee meeting held on 21 June 2024, approved at the ARG CiC meeting on 25 July 2024. This HUTH only meeting for the audited annual accounts and reports was Chaired by Tony Curry in the absence of Jane Hawkard.
Background Information and/or Supporting Document(s) (if applicable)	ARG CiC agenda papers – 25 April 2024. HUTH ARG Committee agenda papers – 21 June 2024
Prior Approval Process	ARG CiC meeting – 25 July 2024.
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

AUDIT, RISK AND GOVERNANCE COMMITTEES-IN-COMMON (ARG CIC)

Minutes of the meeting held on Thursday 25 April 2024 at 9am to 12.30pm in the Boardroom, Hull Royal Infirmary and via MS Teams

For the purpose of transacting the business set out below:

Present:
Core members:

Simon Parkes	Chair of ARG CiC (NLAG) / Non-Executive Director
Jane Hawkard	Chair of ARG CiC (HUTH) / Non-Executive Director
Gill Ponder	Non-Executive Director (NLAG)
Kate Truscott	Non-Executive Director (NLAG)
Mike Robson	Non-Executive Director (HUTH)
Tony Curry	Non-Executive Director (HUTH)

In Attendance:

Lee Bond	Group Chief Financial Officer
David Sharif	Group Director of Assurance
Sally Stevenson	Assistant DoF – Compliance & Counter Fraud - Group
Nicki Foley	Local Counter Fraud Specialist – Group
Rebecca Thompson	Deputy Director of Assurance – HUTH
Jason McCallion	External Audit - NLAG
Chris Boyne	Director, Audit Yorkshire - NLAG
Danielle Hodson	Asst. Internal Audit Manager – NLAG
James Collins	Director (Mazars) – External Audit – HUTH
Ellie Horsley	Assistant Manager (Mazars) – External Audit – HUTH (Observing)
Asam Hussain	Head of Internal Audit (RSM) – HUTH
Robert Knowles	Assistant Manager (RSM) – HUTH
Nicola Parker	Assistant DoF – Planning and Control – Group – items 3.1, 3.2, 3.3, 26.1, 26.2 & 26.3
Rachel Kemp	Deputy Director, D2A Transformation – item 5.3
Sue Meakin	Group Data Protection Officer / Lead for IG – item 17.1
Helen Knowles	Director of People Services – item 17.2
Tony Deal	Group Chief Technology Officer – item 28.2
Andy Hayward	Group Chief Digital Officer – item 28.2
Ian Reekie	Governor Observer – from item 5.3

Key:
HUTH – Hull University Teaching Hospitals NHS Trust
NLaG – Northern Lincolnshire & Goole NHS Foundation Trust

Part One - HUTH Business Items – All NED members plus HUTH only attendees in attendance

Sally Stevenson asked if the meeting could be recorded for the purposes of producing the minutes, advising that the recording would be deleted once the draft minutes were approved as correct. No objections were raised.

1. Welcome and apologies for absence

Apologies were received for Jonathan Lofthouse, Group Chief Executive Officer. Lee Bond was noted as delayed due to traffic problems.

2. Declarations of Interest

Jane Hawkard asked for any declarations of interest and none were made.

3. Annual Governance Issues

3.1 Review of HUTH Accounting Policies 23/24

Nicola Parker presented the report, with key items to note shown on the first page, and advised that the bad debt provision rate for Injury Cost Recovery had reduced to 23.07%; there had been a change in discount rates from HM Treasury to 2.45% from 1.7% last year; the revaluation of land and buildings exercise had been undertaken by Cushmann Wakefield and the IFRS16 leases standard now applied to PFI schemes from 1 April 2023 (for which the Committee had received a briefing paper at its January 2024 meeting).

Kate Truscott asked about pension liabilities arising from early retirement and not being funded. Nicola Parker advised that for anyone retiring now the liability was with the NHS Business Service Authority who run the NHS pension schemes and was not the liability of the Trust. The items shown were legacy items only.

Following discussion, the ARG CiC noted the HUTH Accounting Policies for 2023/24.

3.2 HUTH Going Concern Report 23/24

Nicola Parker reported that the accounts had been prepared on a Going Concern basis and highlighted the risk around the delivery of the Cash Releasing Efficiency Savings (CRES) of circa £47.1m in the draft plan. The 2024/25 Trust planned deficit of £25.3m was currently still in draft with conversations still going on with the ICB and NHS England (NHSE) as to how this figure can be reduced if possible. Final plans were due for submission on 2 May 2024. The liquidity forecast is currently that additional cash support is likely to be needed in the form of Public Dividend Capital (PDC) in the final quarter of the year if the Trust met its CRES targets. If it does not meet its CRES target cash support will be needed before that point, and the Trust are working with NHSE to go through the process of what will be needed to apply for PDC.

Tony Curry asked what the position with going concern would be if the Trust did not meet its CRES plans, etc. Nicola Parker advised that there had been nothing from the Department of Health and Social Care (DHSC) to say the Trust would be wound up in the next financial year, and also the Trust would be supported by NHSE and DHSC with PDC support as necessary.

Following discussion, the ARG CiC approved the Going Concern status for HUTH. This would be included in the Highlight Report to the Group Trust Board to recommend adoption of the Going Concern status.

Lee Bond arrived in the meeting.

3.3 HUTH Draft Annual Accounts 23/24

The paper set out a summary of the highlights for the ARG CiC on pages 1 to 3.

Nicola Parker reported that the year-end reported deficit was £14.4m due to asset impairments in the year but after adjustments was a £20,000 surplus. Exclusions included; donations, revaluations, any gain on PDC in relation to PFI schemes and changes to inventories such as PPE stock given by DHSC – as detailed on page 61 of the accounts.

The cashflow closing position was £37.5m which would be used to pay off the capital creditors in 2024/225 as well as paying tax and National Insurance and any outstanding creditors at the year end. Nicola Parker advised that the Trust would try to manage its cash through the year as best it could through debtors and creditors. The Trust had received £29m PDC for capital schemes during the year. The main change to the accounting policies was the IFRS16 and PFI standard as referred to earlier in the meeting.

NHS Trusts are now required to split income out between fixed and variable elements with Commissioners and this also includes elective recovery funding this year. Income also includes £409k, with a corresponding expenditure item, relating to the consultants pay award and pay reform that came in on 1 March 2024, with these figures being supplied by NHSE.

Capital grants of £592k related to buildings and equipment from charity donations. Other income also included £1.7m for car parking, £2.5m for catering and £800k for accommodation relating to staff.

There had been an increase in staff costs, mainly due to the consultant pay reform and the pay award. Consultancy costs had also increased due to the procurement business case to bring consultants in to look at how to improve collaborative working with HUTH, NLAG and York.

Depreciation costs had increased, as had Clinical Negligence Scheme for Trusts (CNST) costs due to not meeting the maternity elements of the scheme and therefore not receiving a rebate for the maternity elements. CNST liabilities sit with NHS Resolution (NHSR) but are required to be shown in the accounts, and the figures are provided by NHSR. Education costs had fallen. Finance costs had increased due to the implementation of IFRS16.

Assets under construction are £28.3m and include included the Day Surgery, Digestive diseases, Reinforced Autoclave Aerated Concrete (RAAC) and some fees for the new HRI scheme.

The cash balance had fallen within the financial year by £16.2m and this was due to paying off creditors from previous years and an increase in inventory items. Capital creditor's invoices for increasing capital work would be paid in April, May and June of 2024. There had been a reduction in accruals and this related to the pay award for the last financial year. There had been an increase in losses and compensations as the Trust had written off more debt this year relating to overseas visitors.

Mike Robson asked if the accounts still matched despite the pay award changes and Nicola Parker confirmed that they did and explained the accounting treatment. Mike Robson also noted that the cash position on the balance sheet had decreased substantially and asked if this was because of the underlying financial position. Nicola Parker confirmed that this was the case and Lee Bond explained this further.

Jane Hawkard thanked Nicola Parker for the very comprehensive update, and commented that it was an incredible achievement to be able to produce the draft accounts so soon after the year end. Lee Bond added that the Finance teams had had to produce two sets of draft accounts, so even more of an achievement.

The ARG CiC confirmed they had received good assurance from the HUTH Draft Annual Accounts 2023/24 and associated update.

Nicola Parker left the meeting.

3.4 HUTH Draft Annual Governance Statement 23/24 and update on Trust Annual Report

David Sharif presented the HUTH Draft Annual Governance Statement (AGS) 2023/24 to the ARG CiC and advised that the document responded to the guidance dictated by NHSE. The draft AGS was marked up with sections that still required further updates. David Sharif also drew the ARG CiC's attention to the Significant Issues section of the AGS, which is required to show control issues which merit specific disclosure as areas for improvement within the Trust.

The report also highlighted the position with the Trust's Annual Report and progress to date, which David Sharif reported was broadly on course for completion on time.

Kate Truscott asked about the Digital Risks on page six and where these fitted. Lee Bond responded that they would appear on the Risk Register. Rebecca Thompson confirmed that there had been no Digital Risks highlighted in 2023/24 but were included on the Board Assurance Framework in 2024/25.

A number of areas were highlighted by members for further consideration / clarity which included; the RAAC issues (impact on training and whether considered a significant issue), CQC compliance with the registration conditions, Board self-assessment outcomes, ambulance handover improvements and reference to the Trust's role in the wider system. Mike Robson specifically asked that the final section of the report could be strengthened in terms of recognising the significant risks that the Trust were carrying in terms of performance against standards and quality issues. David Sharif agreed to take away all the points raised for further consideration for the AGS.

Action: David Sharif

3.5 HUTH Draft Head of Internal Audit Opinion 23/24

Jane Hawkard noted that this was a draft head of internal audit opinion at this stage and asked Asam Hussain if there was anything specific to draw out. Assam Hussain advised that 2023/24 would be a positive position, consistent with last year's opinion, made up of eight reports received so far with seven positive reports and one partial assurance (sickness absence). Asam Hussain advised that it was still a draft opinion as there were two audits outstanding for completion from 2023/24 which were the Data Protection and Security Toolkit (DSPT) review starting on 9 May 2024 and the Capital Planning review currently undergoing quality assurance checks.

Kate Truscott asked if the sickness absence review report would go to the Workforce, Education and Culture Committee. Lee Bond advised that each completed audit report would be presented to the relevant CiC, adding that it was being considered which was the appropriate CiC for each internal audit report.

Overall, the ARG CiC was assured that the year-end processes were well underway and going well.

4. External Audit (Mazars)

4.1 HUTH Audit Strategy Memorandum 23/24 and Audit Progress Update

The report was taken as read and James Collins advised that there was nothing significantly different from last year's plan, including the significant risks being very similar. James Collins identified the value for money (VFM) work and the significant weakness in arrangements relating to the 'inadequate CQC' reports into maternity and A&E identified last year and the follow up work that will be performed this year. A recommendation made last year in terms of financial plans would also be followed up on this year.

There were no questions raised and the report was accepted by the ARG CiC.

5. Internal Audit (RSM)

5.1 HUTH Internal Audit Progress Report and Associated Reports

All reports in this section were taken as read and Jane Hawkard asked if there was anything specific to draw out. Asam Hussain highlighted the Sickness Absence audit report, receiving partial assurance. Lee Bond asked if management of the roster systems was included in the scope of the audit in terms of how they were configured to manage sickness absence and Robert Knowles confirmed it was.

The ARG CiC discussed the Key Financials Controls audit report and the issue of documentation for leavers not being completed by managers, which resulted in salary overpayments. Gill Ponder advised that this had been a problem for a while at NLAG and asked what more could be done. Lee Bond advised that the numbers were very small compared to the totality, and there was a non-compliance process in place at NLAG where repeat offenders were targeted and this had been discussed at the NLAG ARG Committee previously. Simon Parkes added when this was reviewed at NLAG there were very few instances of repeat offenders following the escalation process, but given the volume of managers it was a difficult to eradicate completely for those managers who had a one off offence. Gill Ponder asked if something more basic could be done. Sally Stevenson added that there were monthly HR bulletins circulated which included reminders for managers to complete leaver forms and other pay impacting change forms on a timely basis.

5.2 HUTH Internal Audit Recommendations Follow-Up Status Report

Robert Knowles presented the Follow-Up Status Report and advised that there were 22 outstanding actions as at 5 April 2024. 18 of these actions related to DSPT and the 2024 audit was now due and these 18 actions would therefore be followed up during that work and either closed or superseded with updated actions. Jane Hawkard advised that she had spoken to Sue Meakin who confirmed that they had closed further actions since the report was produced. Rebecca Thompson advised there were only two overdue recommendations on the follow up system as of earlier that morning.

Robert Knowles added that validation work on the closed actions had taken place and 39 out of 40 actions were confirmed.

Rachel Kemp joined the meeting. Jason McCallion and Ian Reekie also joined the meeting during item 5.3.

5.3 HUTH Discharge Management Action Plan

Rachel Kemp attended the meeting to highlight the new inpatient flow programme following the Discharge Management Audit which had resulted in 30 sub actions included in the recommendations, of which 23 actions are now complete, seven actions closed as duplicative of another/similar action and one remains incomplete but in progress. Rachel Kemp advised that patients on pathway zero leave hospital needing no support from an external agency, etc. and patients on pathways 1 to 3 leave hospital requiring social care or community health support to some degree.

The latest No Criteria to Reside (NCTR) collective figure was 178 which was a reduction on previous weeks. Lee Bond asked if the 178 included pathway zero patients and Rachel Kemp confirmed that it did (47 pathway zero's). Lee Bond asked if there was a target figure for pathway zero on a daily basis and Rachel Kemp advised that it was no more than 15, clarifying that it was set at 15 due to patients who were homeless or had no right to reside and may have a significant stay as a result. Pathway zero patients are monitored. The current length of stay (grouped by Local Authority) for Hull City patients averages seven days and for East Riding patients is five days. The service collectively has additional funding to look at various schemes and this year is looking at homelessness provision to avoid patients staying in hospital longer than necessary.

Jane Hawkard thanked Rachel Kemp for the report and advised that it had given the ARG CiC good assurance around the audit actions being addressed.

Rachel Kemp left the meeting.

6. HUTH Private Agenda Items

There were no private agenda items. A private meeting was scheduled to take place after the meeting with Mazars.

7. Any Other Urgent HUTH Business

There were no urgent items of business raised in the HUTH section of the meeting.

8. Matters for Escalation to the Group Trust Board (Public/Private)

The following HUTH items were agreed to be highlighted to the Group Trust Board:

- The draft annual accounts had been reviewed for HUTH.
- The year-end governance statements were progressing well with a recommendation from ARG to further highlight significant risks in the report;
- There was good progress being made regarding follow Up actions;
- The ARG CIC recommended formal adoption by the Board for the HUTH Going Concern status.

A query was raised around assurance levels and David Sharif advised that he was pulling together an aide memoire/guide for CiC Chairs in feeding back to the Trust Board on a consistent basis what level of assurance they were taking from business items dealt with at their meetings. The draft document will be going to Cabinet and David Sharif will bring to the ARG CiC also. David Sharif clarified that it would not accord with assurance ratings provided by the Trust's various auditors as they have their own levels of assurance they apply in their reports.

9. Matters to Highlight to other Trust Board CIC

The Sickness Absence report would be presented to the Workforce, Education and Culture Committee.

At the conclusion of the HUTH only business section, Jane Hawkard handed over to Simon Parkes, Chair of NLAG ARG CiC to chair the remainder of the meeting.

Part Two – Joint Business Items – NLAG attendees joined the meeting as necessary.

10. Welcome and Apologies for absence for NLAG attendees joining the meeting
Apologies were received for Jonathan Lofthouse, Group Chief Executive Officer.

11. Declarations of Interest for NLAG attendees
Simon Parkes asked for any declarations of interest from NLAG attendees and none were made.

12. Minutes of the Previous ARG CIC Meeting on 25 January 2024
12.1 Public Minutes
The minutes were approved as a true and accurate record of the meeting.

12.2 Private Minutes
The minutes were approved as a true and accurate record of the meeting.

13. Matters Arising
There were no matters arising.

14. Review of ARG CIC Action Tracker
In addition to items evidenced as closed on the Action Tracker, scheduled as separate agenda items at the meeting or not yet due, Lee Bond provided an update on the position with the HFMA financial governance checklist. Lee Bond highlighted that one of the key items in the checklist was the ability of the Finance department to service the rest of the organisation in terms of budget holder meetings, etc. but due to the 7% cost improvement exercise this will impact on the Financial teams and may mean that the Finance team is not able to provide the current level of service to budget holders.

Mike Robson voiced concern around cutting back on Finance staff who are monitoring CRES programmes, etc. and queried whether it was about doing things differently. Lee Bond responded to advise that he had asked the Finance team if they could come up with more automated solutions for transactional work to make the processes more streamlined through technology (Artificial Intelligence). Gill Ponder expressed her concern regarding maintaining grip and control throughout the organisation if there was not the right level of resource in place within the Finance department for monitoring and reporting purposes, etc. Lee Bond advised that conversations were on-going. It was agreed to flag this concern to the Group Board, but it was clarified that it was not to ask for any Board intervention.

Lee Bond to provide an update regarding the HFMA financial governance checklist and Finance resources at a future ARG CiC meeting.

Action: Lee Bond

15. Internal Audit Group Plan
Simon Parkes commented that he was pleased to see that a Group internal audit plan had been developed by the two Trusts Internal Auditors. Lee Bond placed on record his thanks to the Internal Audit teams for developing the plan between themselves and coming up with a workable proposition for a Group internal audit plan.

Tony Curry asked about the Freedom to Speak Up audit for NLAG and Danielle Hodson advised that it had been undertaken at HUTH the previous year and the outline of the scope was in the plan. Tony Curry asked if it was a high priority audit and Simon Parkes responded to say it was a safeguard against things going wrong and also commented that there would be some catch up audits on one side or the other over the next year or so. Lee Bond also commented that it was a follow-up to the Lucy Letby case.

Simon Parkes echoed Lee Bond's thanks to both sets of Internal Auditors for their joint working and professionalism to overcome challenges posed through having a Group arrangement, recognising auditors reporting requirements for both Trusts individually, and for developing a credible internal audit plan. The coming together of the two Internal Audit teams with a joint Group plan was agreed to be highlighted to the Group Board.

The ARG CiC approved the final draft of the Group Internal Audit plan for 2024/25.

16. Counter Fraud

16.1 Group LCFS Progress Report

The report was taken as read, with Nicki Foley highlighting two new fraud risks in relation to abuse of the earnings on demand app and abuse of the salary sacrifice facility. Nicki Foley was working with Lucy Vere, Group Director of Learning and Organisational Development with a view to making fraud awareness training mandatory for HUTH staff as it was already at NLAG. The Local Counter Fraud Policy had been updated with minor changes and the ARG CIC was informed that there was a local proactive exercise (LPE) in the pipeline instigated by the NHS CFA regarding procurement. There had been ten new fraud referrals since the last meeting and these were detailed in the report with updates on on-going / closed cases.

Kate Truscott thanked Nicki Foley for the comprehensive report, and queried a case ongoing since 2023. Nicki Foley advised that this was due to prioritisation and the urgency of the case compared to other live and more serious cases.

16.2 Group Annual Counter Fraud Operational Plan 2024/25

The Group Counter Fraud Operational Plan 2024/25, approved by the Group Chief Financial Officer, was presented to the ARG CiC for information. Simon Parkes noted the harmonisation of the plan between the two Trusts which was reassuring.

The ARG CiC broke for a short recess. Sue Meakin and Helen Knowles joined.

17. Management Reports for Assurance

17.1 Group IG Highlight Report

Part of this item minuted as a private minute.

Gill Ponder asked how long the Group would have to achieve the 95% Information Governance (IG) training compliance before the DSP Toolkit was submitted, as it was the only outstanding action for NLAG. Sue Meakin advised that the deadline was 30 June 2024. Support was being offered to staff in the form of email reminders for those not compliant, as well as seeking support from line managers to push for compliance for their staff and to monitor this, as well as offering online training or a booklet to complete.

In response to a query from Kate Truscott around Lorenzo, Sue Meakin advised that a single process was required across the Trusts regarding Subject Access Requests (SARS) to develop best practice across the Group. The two Trusts teams were talking to one another to make improvements as necessary.

Robert Knowles asked if there was a process to let staff know if their training was expiring between now and June 2024. Sue Meakin advised that there was a full list of staff who were non-compliant and also those due to become non-complaint. Both the online training and completion of the booklet counted towards compliance, however staff tend to utilise e-Learning (provided by NHSE) rather than the booklet. A review was ongoing to refresh how the Group delivered mandatory training in future, to encourage staff to do their mandatory training recognising that their time was precious.

Tony Curry expressed his concern regarding some of the date commitments being missed on the DSP Toolkit and asked when dates would be added and executed. Sue Meakin advised that Andy Haywod, the new Group Chief Digital Officer, and Tony Deal were reviewing these items and any work already done on the south bank would be mirrored on the north, which could result in some quick wins.

Simon Parkes advised that he would write to the relevant action owners to clear any outstanding issues at HUTH. In addition, he would write to the new Group Chief Digital Officer regarding the issues around Lorenzo and Subject Access Requests.

Action: Simon Parkes

Sue Meakin left the meeting.

17.2 eRostering Rollout and Management of Doctors Update

Helen Knowles provide a verbal update to the ARG CiC regarding the rollout of e-Rostering to medical and dental staff across the Group, for which she now had responsibility for at NLAG as well as HUTH since February 2024. Helen Knowles advised that she was now looking at rostering across the Group. In order to demonstrate the work going on for the new Group structure, Helen Knowles used Digestive Diseases as one example of mapping existing rosters into the new care group structures and displayed this on screen to the ARG CiC. The two Trusts are at different stages of development for medical staff on eRoster, with NLAG having been doing so for a number of years and HUTH only recently.

The ARG CiC heard about the work being done by Helen Knowles teams to develop a joint plan for eRoster rollout, but this comes with many challenges due to the complexities of some multi-specialty rosters. There is a need for the teams involved in compiling the rosters to now engage closely with Clinical Directors to determine how they want the rosters designed and for them to engage and take ownership of roster design to ensure that they deliver what is needed. Lee Bond acknowledged the complexities of the rosters and was concerned they would become even more complex now, with the risk of duplication and/or gaps.

Mike Robson queried the role of the new Clinical Directors in this, stating this was a clinical issue and they should therefore be working with HR to ensure the rotas were in place and appropriate from a clinical perspective. Gill Ponder supported this view.

Tony Curry asked if the clinical teams were adequately trained, skilled and supported for eRostering purposes. Helen Knowles stated that she had some good

people who could help design rosters but it needed clinical engagement to make the rosters work and advised that the next steps were to link in with the Site Medical Directors and agreed that clinical engagement was key. Kate Truscott supported this view.

Following discussion, the ARG CiC agreed that this was a long standing item which was still struggling to make progress and this had now become a complex piece of work as a result of the care group structure, which needed clinical leads to take ownership and work with the eRostering team to design effective rosters and provide assurance over the rollout plan for doctors.

It was agreed to escalate this matter to both the Workforce, Education and Culture Committees-in-Common to take forward as a workforce issue. It was acknowledged that this was not a criticism of Helen Knowles or her team however, it had simply now become a very complex piece of work as a result of the care group structure coming into play. David Sharif suggested asking WECC to review the objectives of the eRostering exercise recognising the financial context the Trust now had to work within, to develop clear new goals.

Action: Simon Parkes

It was also agreed to highlight the issue to the Trust Boards-in-Common that this was now a complex piece of work and effectively required a new rollout plan.

Simon Parkes thanked Helen Knowles for her update. *Helen Knowles left the meeting.*

17.3 Group Assurance Map

Simon Parkes summarised the paper which set out the responsibilities of each of the Group's Committees-in-Common with a view to ensuring no gaps in assurance across the range of activities.

Tony Curry raised where the scope of Digital would sit and advised that he was discussing this with David Sharif and there may be some movement between CiC's. Lee Bond commented that the Capital Planning and Delivery was showing in both Capital and Major Projects CIC and the Performance, Estates and Finance (PEF) CIC columns of the document. David Sharif agreed to amend accordingly and remove from the PEF CiC.

Action: David Sharif

Simon Parkes added that the document was live and would continue to develop as CiC's developed into a routine, and may be reviewed / adjusted, in line with the process for adjusting terms of reference, etc.
Simon Parkes stated that the next items at 17.4 to 17.8 were for noting and assurance only, but wished to advise of an action under 17.8 and Gill Ponder also wanted to ask a question relating to item 17.4.

Nicola Parker re-joined the meeting.

17.4 Review of Waiving of Standing Orders – Group

Gill Ponder noted the number of waivers and year end spending pressures, but queried whether there should be a review of the status of contracts and being in a prepared state to avoid waivers. Jane Hawkard agreed with this but considered that the collaborative plan produced by Edd James would give the ARG CiC some of that assurance.

Jane Hawkard raised the CEO sign off option when the waiver did not meet the criteria, adding that this did not seem correct, although acknowledging that this had been discussed before. The ARG CiC discussed this and Lee Bond stated that the CEO would have to be accountable for any such decision and that such waivers would be exceptionally rare as they would usually fall into one of the other waiver categories. Lee Bond advised that reasons for tender waivers in the main were single supplier or specialist goods. He added that the Scheme of Delegation was being reviewed with a view to harmonising it across the Group, so that it was consistent irrespective of where Procurement teams or budget holders sat. Lee Bond suggested that such waiver items could be signed off by both the CEO and the Group CFO, and the ARG CIC were content with this suggestion of double sign off.

Action: Lee Bond

17.5 Review of Losses and Compensations 23/24 – Group
The ARG CiC received the report and no issues were raised.

17.6 Review of Standards of Business Conduct Declarations 23/24 – Group
The ARG CiC received the report and no issues were raised.

17.7 Review of Salary Overpayments 23/24 – NLAG
The ARG CiC received the report and no issues were raised.

17.8 Document Control Report - NLAG
Simon Parkes advised that he had written to Dr Kate Wood and Shaun Stacey regarding the high and moderate risk documents that were overdue, and asked them to provide assurance that the documents are being brought up to date and that there are no risks to patient safety. Simon Parkes would update the ARG CiC on their responses at the next meeting.

Action: Simon Parkes

18. Policies for Review / Approval

18.1 HUTH Declaring Gifts and External Interests Policy
Rebecca Thompson presented the paper which highlighted minor changes to the policy and which also included an updated fraud section. The policy was presented for approval by the ARG CiC.

The ARG CiC approved the updated policy.

19. Highlight Reports and Action Logs form Board Sub-Committees-in-Common
19.1 Performance, Estates and Finance CIC
19.2 Capital and Major Projects CIC
19.3 Quality and Safety CIC
19.4 Workforce, Education and Culture CIC
19.5 Health Tree Foundation Committee – NLAG
19.6 Annual summary of Remuneration CIC Business 23/24

No questions were raised in respect of items 19.1 to 19.6.

20. ARG CIC Governance Items

20.1 HFMA NHS Audit Committee Handbook Review
The ARG CiC received the paper setting out seven items for consideration by the CiC as a result of a review of the new HFMA NHS Audit Committee Handbook

published in March 2024. The paper proposed a number of actions for the ARG CiC to agree.

The ARG CiC discussed the updated Handbook in particular the attendance of the Chair and the CEO at meetings of the ARG CiC. The Terms of Reference of the ARG CIC were clear about the attendance of the Chair but would need amending to state that the CEO did not have right of attendance at each meeting but could attend if requested. Gill Ponder suggested adding in the attendance of the Vice Chairs and NLAG Governor observer to the Terms of Reference. Simon Parkes confirmed that the Group Chair and CEO are invited routinely to the annual reports and accounts meeting each year.

The ARG CiC agreed to the proposed actions in the paper including adjusting the ARG CiC Terms of Reference in relation to the attendance of the Group Chair and CEO. Sally Stevenson to make the adjustments as agreed. The adjustments would then be presented to the Group Board for approval as part of the three month review of CiC's paper being submitted to the June 2024 Group Trust Board meeting by David Sharif.

Action: Sally Stevenson / David Sharif

21. Private Agenda Items

There were no private agenda items discussed.

22. Any Other Urgent Joint Business

There were no other urgent joint business items discussed.

23. Matters for Escalation to the Group Trust Board (Public/Private)

The following joint items were agreed to be highlighted to the Group Trust Board:

- Provision of Financial Services
- Information Governance training compliance
- eRostering rollout update / Group plan
- HFMA NHS Audit Committee Handbook Review
- Review of CIC Meetings

24. Matters to Highlight to other Trust Board CIC

The following item was agreed to be highlighted to the Workforce, Education and Culture CiC:

- eRostering rollout update / Group plan

At this point Jane Hawkard and Simon Parks raised the high level risk management process and how it linked to the Board Assurance Framework, following a referral earlier in the week from the Capital and Major Projects CiC that Committees had not seen a risk register for some time and querying whether there was a gap in assurance and any mitigations which existed. The ARG CiC discussed whether there should be any reference to this in the AGS or not.

Simon Parkes suggested that David Sharif prepare a paper setting out the facts and the other methods of assurance in mitigation and circulate this outside of the meeting to the two ARG CiC Chairs to enable a view to be taken on whether it is included in the AGS.

Action: David Sharif

25. Review of the Meeting

Simon Parkes asked for any feedback either at that time or outside of the meeting. Gill Ponder commented on the volume of papers, adding that she had read 875 pages in preparing for the meeting. Tony Curry also commented that there had been three CiC meetings that week, adding his concerns around the amount of detail in CiC reports and poor quality of some executive summaries in general which were not drawing out the key issues sufficiently.

David Sharif responded that meeting sequencing was a challenge and would continue to be so, but anticipated that the planned report writing training would help staff when writing their reports for CiCs and the Group Board. Gill Ponder also raised her concern regarding the sequencing of the meetings on consecutive days, etc. Mike Robson offered an alternative view on the difficulties of meeting sequencing. Gill Ponder also commented on late papers generally.

Simon Parkes acknowledged the volume of work in preparing for the meeting and it was agreed to add this to the Board Highlight report and in addition the NED committee could also pick up the issues.

Following the conclusion of the joint business section, NLAG attendees left the meeting.

Part Three - NLAG Business Items – All NED members plus NLAG only attendees in attendance.

26. Annual Governance Issues – NLAG

26.1 Review of NLAG Accounting Policies 23/24

Nicola Parker advised that the IFRS16 change, discussed earlier in the HUTH section, did not impact on NLAG as there were no PFI schemes within the Trust. The report also detailed in-year revaluations and changes in bad debt provisions.

The ARG CiC noted the HUTH Accounting Policies for 2023/24.

26.2 NLAG Going Concern Report 23/24

Nicola Parker presented the report and advised that the draft CRES target for 24/25 was £37.5m and it was likely that the Trust would require cash support in Q3 or sooner if the CRES targets were not being met.

Following discussion, the ARG CiC approved the Going Concern status for HUTH and agreed to recommend this to the Group Trust Board. This would be included in the Highlight Report to the Group Trust Board.

26.3 NLAG Draft Annual Accounts 23/24

The paper set out a summary of the highlights for the ARG CiC on pages 1 to 4.

Nicola Parker presented the NLAG draft accounts and advised that they were split by Group, clarifying that in this context Group meant NLAG and the Charitable Fund for NLAG, not the Group between NLAG and HUTH.

The deficit for the Group was £18.63m, the Charity was an £11k surplus and the adjusted financial performance of the Trust was a £125k surplus. The cash balance was £41.3m and this would be used to pay outstanding capital creditors and other trade creditors throughout the coming financial year.

Nicola Parker highlighted; the increased interest rates, larger spends on intangible assets (Pathology LIMS system and Lorenzo), higher capital creditors at the end of the year, £84k in donated items and the deficit in car parking income. The Trust had received £32m in PDC funding and the schemes this related to are listed in the accounts.

The Consultant national pay award was shown separately in the accounts (£168k) and there had been an increase in private patients, overseas and recovery income. Covid expenditure reimbursement had stopped in 2023/24.

There was £2m highlighted for car parking and £2.3m for staff accommodation and a profit on the sale of some diagnostic equipment. Staff costs had increased, as had depreciation and impairments. Buildings had been upgraded but their value had not increased. Overseas bad debt had increased and there had been £240k incurred in redundancy costs this year.

There had been an increase in stock overall but a reduction in drugs, PPE and fuel although these were offset by other costs. Capital creditors had increased reflecting the volume of spend in the last quarter of the year and accruals for annual leave (£6m) had been made. This year the Trust owed additional PDC and this would be paid in September 2024.

There was still a provision for the clinician's pensions. £745k related to some outstanding RAAC at Scunthorpe General Hospital.

Simon Parkes thanked Nicola Parker her comprehensive summary of the NLAG draft accounts, and invited questions. Gill Ponder queried her understanding of an aspect of impairments and this was explained by Nicola Parker and Lee Bond.

Simon Parkes stated that it was a remarkable achievement to get both sets of financial statements out in draft format so quickly and was a real tribute to financial management that it was able to be done and thanked Nicola Parker and the Finance team, on behalf of the ARG CIC, for their hard work in producing the draft accounts.

Nicola Parker left the meeting.

26.4 NLAG Draft Annual Governance Statement 23/24 and Update on Trust Annual Report

David Sharif presented the NLAG draft AGS which highlighted the changes from last year. He advised that it had a deadline of 6 August 2024 (audited accounts NLAG ARG Committee meeting date) and the ARG CiC would receive the final draft version at the July 2024 meeting and he would be happy to take comments on the draft AGS outside of the meeting. Gill Ponder advised she had the same comments as for the HUTH AGS.

26.5 NLAG Draft Head of Internal Audit Opinion 23/24

Simon Parkes noted there was no overall opinion provided as yet. Chris Boyne gave an update and advised that there were three key elements to the opinion, namely the review of the Board Assurance Framework and Risk Management Arrangements for which the field work was now completed and a draft report would be issued. Secondly the range of opinions across the year, but these were good so far. The final audits are close to completion. The third element was the issue of recommendation tracking and this would be discussed at that item on the agenda,

but he was aware that a lot of work was going on to address the 33 overdue recommendations.

Chris Boyne advised that the opinion would be available for the July 2024 ARG CiC meeting, but added that early indications were positive though.

Lee Bond asked about the eight outstanding audit assignments and queried the timescale for completion on these. Danielle Hodson advised that seven were virtually finished and one was late being started but she was working to the end of May 2024 for completion, in preparation for the annual report.

27. External Audit (ASM)

27.1 NLAG Audit Planning Report 23/24 and Audit Progress Update

Jason McCallion highlighted that work on the audit planning process had started and ASM had held the planning meeting with the Finance team and there were no significant findings to date. The audit would start in the first week of June 2024 (which is different to the rest of the NHS accounts timetable, but was as agreed last year with NHSE and the Trust when appointed as the Trust's External Auditor) and they would be well on track for sign off on 6 August 2024.

There were no questions from the ARG CiC.

28. Internal Audit (Audit Yorkshire)

28.1 NLAG Internal Audit Progress Report

Danielle Hodson advised they were on track to deliver the plan by the end of May 2024, as discussed earlier, adding that Andy Haywood was attending to the discuss a particular report later on the agenda which had received limited assurance.

Lee Bond referred to the reference in one of the reports to the Standing Financial Instructions and Scheme of Delegation being due in April, and advised that these were close to being done.

Tony Deal joined the meeting. The agenda was then taken out of sequence to allow for the arrival of Andy Haywood for item 28.2.

28.3 NLAG IA Recommendations Follow-Up Status Report

Simon Parkes noted the level of overdue recommendations. Lee Bond advised that a significant number had only recently become overdue and was of the view that it could be managed through the routine process. The ARG CiC was assured that there was a process in place for sending regular reports to Executive Directors for review/action and that overdue recommendations were also monitored by the monthly operational Group Risk and Assurance Committee, and therefore held an expectation that this would have the necessary effect on reducing the number of overdue recommendations.

The ARG CiC noted the report and it was agreed to highlight this issue to the Group Trust Board.

Due to technical issues, Andy Haywood was still delayed joining the meeting but Tony Deal was present so the meeting progressed to item 28.2.

28.2 NLAG IA Report – Change Control Management

The Change Control report received 'limited assurance'. Tony Deal advised that the audit took place just as Digital Services were beginning a piece of work to look at IT service management methodologies and implement them within both organisations within the Group. The change management process had now been implemented. There is a full Change Management Board every week now and all changes relating to technical services are going through the Change Board for approval as appropriate. There had been engagement with the clinical system admin teams to roll out the change process to them. Work had also been ongoing with Estates and they also attend meetings to discuss major estates works and align with digital services as necessary. A Change Manager is being recruited to oversee the change management on a weekly basis. Tony Deal added that there had been a lot of progress and that all actions would be completed by September 2024.

In response to a question from Tony Curry, Tony Deal confirmed that it was a Group approach with the north and south bank technical teams working together across Digital Services as a Group. The Change Manager would also be a Group role. Tony Curry asked if this extended to Information Services. Tony Deal confirmed they were part of the programme before they split away, but this will still continue. Simon Parkes asked if the two 31 March 2024 recommendations were complete and Tony Deal confirmed they were. Danielle Hodson advised the two recommendations in question were still showing as outstanding on the electronic tracker system and asked that they be updated on the system to close them down. Tony Deal agreed to update / close the actions down.

Andy Haywood joined the meeting.

Andy Hayward advised that he was reviewing the broader change management processes with support services which were not within Digital Services remit, such as power.

Simon Parkes commented the ARG CiC were assured by the update and thanked Tony Deal and Andy Haywood for attending the meeting. *Tony Deal and Andy Haywood left the meeting.*

29. Private Agenda Items

There were no NLAG private agenda items to be discussed.

30. Any Other Urgent NLAG Business

There was no urgent NLAG business to discuss.

31. Matters for Escalation to the Group Trust Board (Public/Private)

The following NLAG items were agreed to be highlighted to the Group Trust Board:

- The ARG CIC recommended formal adoption by the Board for the NLAG Going Concern status.
- The draft annual accounts had been reviewed for NLAG.

32. Matters to Highlight to other Trust Board CIC

There were no items raised.

33. ARG CIC Workplan

Jane Hawkard noted that the annual review of the Board Assurance Framework and Risk Register process was due at the July 2024 meeting. The ARG CiC confirmed that this was timely given earlier discussions.

34. Review of Overall Meeting

Simon Parkes asked if there were any additional comments to those already discussed, adding that if there were any comments on reflection in terms of what should be done differently then attendees should feel free to share and any suggestions would be considered.

Lee Bond reflected on the length of the agenda despite spending time considering business items that needed to be on it in advance of the meeting and noted nothing on it was a luxury. Lee Bond suggested synthesising the reports into a one or two page executive summary, but queried whether the detail was still required behind it. There was a detailed discussion regarding executive summaries and the level of detail required, and there were some differing views in this regard. It was also commented that more reports could be combined into Group reports over time as Group reporting evolved, including Internal Audit progress reports with the agreement of a Group internal audit plan.

It was also acknowledged that the ARG CiC only meet five times a year and as a result have a significant amount of business at each meeting particularly as a joint committee.

Simon Parkes reminded the CiC that the two sovereign organisations needed to produce their accounts separately, as well as two AGS documents, etc. It was also the nature of Audit Committees that there was a lot of documents / detail and the real problem that week had been the cumulative volume of papers due to having several CiC meetings in one week.

It was agreed that specific feedback would be provided to Executive colleagues regarding the level of detail required for their reports at future meetings, and then start to provide the feedback to work together and reduce the volume of papers.

Gill Ponder suggested a more radical solution by reverting back to separate meetings of the ARG Committees to review statutory documents, which was being done for the audited accounts meeting. An alternative view on this suggestion was offered, in terms of the fact that it would add to the existing meeting burden. Simon Parkes concluded the discussion by saying that all suggestions would be considered. Simon Parkes thanked everyone for attending and for the Executives preparing papers, etc.

35. Date of the next meeting.

The next meeting of the HUTH Audit, Risk and Governance Committees-in-Common would be held on Friday 21 June 2024 at 9am to 10.30am in the Boardroom, Castle Hill Hospital. (HUTH Audit Annual Account to be presented – HUTH NED's/Attendees only).

The next full meeting of the Audit, Risk and Governance Committees-in-Common would be held on Thursday 25 July 2024 at 9am to 12.30pm in the Boardroom, DPoWH and via MS Teams.

The meeting ended at 12.30pm.

Hull University Teaching Hospitals NHS Trust

HUTH AUDIT, RISK AND GOVERNANCE COMMITTEE

Minutes of the meeting held on Friday 21 June 2024 at 9am to 10.30am via MS Teams

For the purpose of transacting the business set out below:

Present:
Core members:

Tony Curry	Non-Executive Director (HUTH) (Chair)
Helen Wright	Non-Executive Director (HUTH)

In Attendance:

Sean Lyons	Group Chair
Jonathon Lofthouse	Group Chief Executive
Stuart Hall	Non-Executive Director / Trust Vice Chair – from 9.35am
Lee Bond	Group Chief Financial Officer
David Sharif	Group Director of Assurance
Nicola Parker	Assistant DoF – Planning and Control – Group
Sally Stevenson	Assistant DoF – Compliance & Counter Fraud - Group
Rebecca Thompson	Deputy Director of Assurance – HUTH
James Collins	Director (Forvis Mazars) – External Audit
Louise Stables	Audit Manager (Forvis Mazars) – External Audit
Ellie Horsley	Assistant Audit Manager (Mazars) – External Audit
Asam Hussain	Head of Internal Audit (RSM)

Key:
HUTH – Hull University Teaching Hospitals NHS Trust
NLaG – Northern Lincolnshire & Goole NHS Foundation Trust

Prior to the start of the meeting Sally Stevenson asked if the meeting could be recorded for the purposes of producing the minutes, advising that the recording would be deleted once the draft minutes were approved as correct. No objections were raised.

1. **Welcome and apologies for absence**
   Tony Curry, as Chair of the meeting in the absence of Jane Hawkard, welcomed those present to the meeting. Jane Hawkard's apologies were noted. It was also noted that Stuart Hall would be delayed in arriving at the meeting.

2. **Declarations of Interest**
   Tony Curry asked for any declarations of interest and none were made.

3. **Minutes of the Previous ARG CiC Meeting on 25 April 2024 / Matters Arising / Review of ARG CiC Action Tracker**
   Deferred to the next full meeting of the Audit, Risk and Governance Committees-in-Common (ARG CiC) in July 2024.

4. Public Disclosure Documents

4.1 HUTH Audited Annual Accounts 2023/24

Lee Bond introduced the item and advised that the Committee had seen the draft accounts at the April 2024 meeting and the accounts had now been through the external audit process. A list of changes made since the draft accounts were viewed by the Committee had been provided with the paper, which Nicola Parker ran through, as follows:

Page 2 – Statement of Comprehensive Income - deficit for the Trust for the year had increased by £320k to £14,677k this was due to an impairment of a building with Reinforced Autoclave Aerated Concrete (RAAC) which was demolished, which was written off to revaluation reserve and should have been an impairment. The overall control total at note 44 had not changed as the impairment was removed.

Page 4 – Statement of Comprehensive Income - Expenditure transfer from the revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits or reduction in service potential - £320k moved from Revaluation Reserve to Income & Expenditure (I&E) reserve.

Page 7 - Note 1.2 Going Concern - fourth paragraph a new note was added ‘There are no material uncertainties'.

Page 21 - Note 1.25 Standards, Amendments and Interpretations in Issue but not yet Effective or Adopted - a sentence has been added 'The impact of the two International Financial Reporting Standards (IFRS's) on the Trust is not expected to be material.’

Page 21 - Note 1.26 Amended to show Critical Judgements and Sources of Estimation Uncertainty separately.

Page 25 - Note 4 Fees and Charges - Staff and visitor catering income for 23/24 and 22/23 was amended to balance to the Trust Accounts Consolidation (TAC) forms. It has not changed any of the income positions.

Page 27 - Note 6.1 Net impairments increased by £320k due to the RAAC building demolition.

Page 29 - Note 8 Employee benefits - month 12 pension costs of £3.6m included in salaries and wages, social security and apprentice levy figures, this was moved to NHS Pensions. This has not impacted on the overall total, just the split.

Page 41 - Note 23.1 Receivables - Of which receivable from NHS and Department of Health and Social Care (DHSC) group bodies amended. Current from £13,999k to £13,362k and non-current from £1,007k to £0k. This was a formula error within the national template.

Page 46 - Note 27.1 Payables - Of which payables from NHS and DHSC group bodies amended. Current from £10,151k to £9,988k. Again, this was a formula error in the national template.

Page 60 - Note 40 External Financing Limit amended to £38,367k.

Nicola Parker advised that these were all the changes to the accounts, pending any further narrative changes arising from the quality review process being performed by Forvis Mazars. Lee Bond summarised the position and commented that everything was in pretty good order.

Jonathan Lofthouse asked if the changes he had requested had been made and Lee Bond advised that the changes would be in place on the final copy for his signature. James Collins advised that everything would be finalised by Wednesday 26 June 2024. Nicola Parker confirmed that the audited financial statements would be submitted to NHS England by the deadline of 28 June 2024. Nicola Parker also confirmed that the changes to the narrative in the accounts requested by the Chief Executive had been made.

Under the delegated authority given by the Trust Board in June 2024, the Audit, Risk and Governance Committee accepted and approved the 2023/24 Accounts, subject to any last minute minor adjustments identified during the quality review being undertaken which would be contained within their follow-up memo.

4.2 HUTH Audit Completion Report inc. Letter of Representation, Audit Opinion and Consistency Opinion 2023/24

James Collins presented the report and advised that it had been prepared the previous week and there were still some outstanding items but these were almost complete but there were no significant issues to raise.

James Collins advised that based on the final financial statement figures and other qualitative factors the overall materiality applied to the audit was £17.7m using a benchmark of 2% gross operating expenditure. The final performance materiality was £13.2m. James Collins wanted to draw this to the Committee's attention to give context to the unadjusted misstatements.

James Collins reminded the Committee that the risks had been presented in their audit plan which went to the April 2024 meeting and these had not changed. A significant piece of work had been undertaken during the audit on the new PFI element relating to IFRS16, but there were no matters in relation to this to bring to the Committee's attention.

Louise Stables talked through the significant risk areas they consider during an audit and advised that there were no issues regarding the management override of controls where the work was concluded, with nothing to report. In relation to the risk of fraud in revenue recognition their work was concluded, and an item not contained in the report, as it was identified since the report was drafted, related to an error of £48k in relation to cut off (income). Louise Stables explained this error is required to be extrapolated across the whole population and gives a figure of £3.9m as an unadjusted misstatement. This figure is not material, but will be reported in their follow-up memo.

In terms of risk of fraud in expenditure their work was concluded and there was nothing to draw to the Committee's attention. The valuation of property, plant and equipment identified an error of £320k which had been adjusted in the financial statements, as Nicola Parker had already mentioned. There was also nothing identified from their work completed on IFRS and PFI requirements.

Internal control recommendations had been made resulting from the audit; one relating to the evidence to support the prices used for inventory for the stock counts

they attended; one relating to the inclusion of consignment stock in the year end stock count they attended; and a recommendation around evidence for accruals. Similar recommendations were made last year.

Louise Stables highlighted the unadjusted misstatements. In addition to the one already mentioned, another was identified involving a variation of £60k in relation to the evidence supporting the prices for stock counts. Once extrapolated this equated to £6.4m but again this was not classed as material, even when taken together with the other item.

Lee Bond commented that it was disappointing to see the issue of stock takes being raised again in their audit, adding the Finance team have already taken action to amend the stock sheets in relation to consignment stocks. Lee Bond went on to state that the Finance teams were aware of the recommendations around stocks and backing documents for accruals and this would not be seen again next year, having stressed the importance of this at all times of the year.

Sean Lyons asked for clarification on the extrapolation formula and Louise Stables explained this, adding that it did not mean this level of error actually existed just that it could potentially if representative of the total population. Sean Lyons also queried what would happen if the errors were found to be material and James Collins advised that if this situation were to arise at any time further work would be carried out to determine if it was isolated or not.

Helen Wright suggested that the External Audit recommendations and agreed actions should be added to the next ARG CiC agenda for further scrutiny and monitoring to ensure these issues won't be seen again next year. Lee Bond was in agreement with this suggestion.

Action: Lee Bond

James Collins also informed the Committee that the firm had changed its name to Forvis Mazars following an alliance with another firm in early June 2024, but this would have no impact on the service to the Trust it was merely a branding matter for reports, etc.

James Collins advised that the External Auditor is required to produce an Auditors Annual Report as part of their responsibilities, which is very similar to the content of the Audit Completion Report with the main difference being the Value for Money (VFM) commentary. The VFM narrative is shown in draft form in the Audit Completion Report for the benefit of members, but the substance of what they were saying around VFM wouldn't change. James Collins highlighted that they would be once again reporting the significant weakness of arrangements in relation to the CQC inspection. They have performed work this year to satisfy themselves there was no evidence of additional weakness and appropriate action has been taken with evidence of improvements being made, however because the CQC had not re-inspected the Trust they were not able to remove the significant weakness from their VFM narrative. This would be reviewed again once the CQC had re-inspected the Trust.

The draft letter of representation was also contained within the paper. The overall opinion was unqualified.

The Audit, Risk and Governance Committee received the Audit Completion Report 2023/24 and approved the signing of the Management Representation Letter.

4.3 HUTH Annual Governance Statement 2023/24
David Sharif presented the Annual Governance Statement (AGS) which is a mix of prescribed text and structure from the Group Accounting Manual (GAM) the Trust follows. The AGS covered 2023/24 and this time presented a significant period of change for the Trust leading to the formation of the Group structure, etc. David Sharif advised that there would be a final read through of the document as he had noted some typographical errors on reading it again.

David Sharif highlighted the formation of the Group Cabinet Risk and Assurance Committee earlier in the year, adding that this was an important piece of governance within the Trust in relation to transition and realignment of risk management processes. David Sharif also noted the positive Head of Internal Audit Opinion for the year. David Sharif also drew the Committee's attention to the significant internal control issues shown on page 13 giving a transparent assessment of the issues.

Lee Bond agreed with the list of significant control issues which needed to be managed, with the exception of the inclusion of reference to the RAAC issue, which he stated was an issue but was managed quickly and therefore now resolved. It was agreed that the RAAC item, considered to be an event rather than an issue, would be removed from the list of significant control issues in the AGS.

Helen Wright asked David Sharif how the Trust was sighted on the sickness absence issue identified by Internal Audit commenting that she was concerned from both a staff wellbeing and cost challenge perspective. David Sharif responded that it was firmly in the sights of the Workforce, Education and Culture Committees-in-Common (WEC CiC), but would furnish Helen Wright with the workplan items from WEC CiC, and details of other routine performance metrics on sickness absence received by that Committee. It was also discussed at the Quality and Safety CiC.

Action: David Sharif

Sean Lyons asked that a check was carried out to ensure that all the significant issues identified in the AGS were being scrutinised at the relevant Committees-in-Common to monitor progress of the issues. He added that the terminology relating to patient safety culture should be made more specific if it appropriate to do so.

Action: David Sharif

David Sharif thanked Rebecca Thompson for her work on compiling the AGS. Sean Lyons echoed these thanks.

With the above agreed amendments, the Committee approved the Annual Governance Statement 2023/24.

4.4 HUTH Annual Internal Audit Report and Head of Internal Audit Opinion 2023/24
Asam Hussain presented the report which gave the Trust a positive Head of Internal Audit Opinion for 2023/24. The programme of internal audit work carried out had identified some enhancements and these were being monitored as audit actions. There had been eight positive audits and one negative audit in 2023/24, the negative audit related to sickness absence. The actions from this audit, and all others, were being tracked through the Audit, Risk and Assurance Committees-in-Common.

Asam Hussain advised that there was nothing of significant concern to raise for the AGS. Asam Hussain stated that once the last report (Data Security and Protection Toolkit) had been completed the Annual Internal Audit Report would be circulated as a final, but confirmed that the opinion would be as stated in the draft report.

Sean Lyons queried whether the sickness absence system was at fault or compliance with the process. Asam Hussain advised that it was mainly due to return to work forms not being completed and lack of evidence of the meetings taking place, therefore an issue of compliance with the process.

Tony Curry acknowledged the work done on the annual audit plan and thanked Asam Hussain and his team.

Helen Wright referred to the Board assessing its risk appetite across certain areas, and how very low risk appetite impacts the Internal Audit Plan with more audit work going on in such areas. Sean Lyons responded that David Sharif would be taking the Board through this at an event on 2 July 2024.

Following discussion, the Committee noted the positive Head of Internal Audit Opinion for 2023/24.

4.4 HUTH Trust Annual Report 2023/24

David Sharif thanked all those who had contributed to the Trust's Annual Report for 2023/24, and thanked Rebecca Thompson for orchestrating it. It is final subject to the correction of some minor typographical errors that had been identified. David Sharif added that it was a public facing document that would be formatted in the corporate branding before being published. It is a lengthy document given the nature of changes over the last year into the Group model, and directed attendees to review the Remuneration section specifically, given usual external interest in this element of the Annual Report.

Jonathan Lofthouse asked when he and the Trust Chair would get the absolute final version of the document and Rebecca Thompson advised that it would be by 28 June 2024, in line with the financial statements discussed earlier.

Tony Curry queried whether the Annual Report was substantially complete, subject to the correction of any typographical issues, and David Sharif confirmed that it was.

The Audit, Risk and Governance Committee approved the substantial draft of the Annual Report 2023/24 subject to any final minor changes.

5. Documents for Review / Approval

5.1 HUTH Audit, Risk and Governance Committee Annual Report to the Trust Board 2023/24

Tony Curry outlined the HUTH Audit, Risk and Governance Committee Annual Report to the Trust Board, highlighting that it provided a summary statement of how the Committee had discharged its duties on behalf of the Board over the previous year. Tony Curry noted the review of Committee's detailed workplan and Terms of Reference in line with the latest Healthcare Financial Management Associated (HFMA) NHS Audit Committee Handbook.

There were no questions from the Committee.

The Audit, Risk and Governance Committee approved the submission of the HUTH Audit, Risk and Governance Committee Annual Report to the Trust Board 2023/24.

6. Private Agenda Items

There were no private agenda items to note.

7. Any Other Urgent Business

There were no urgent items of business raised.

8. Matters for Escalation to the Group Trust Board (Public/Private)

The items of business from the meeting were agreed to be highlighted to the HUTH Trust Board.

9. Matters to Highlight to other Trust Board CIC

None.

10. Date of the next meeting.

The next full meeting of the Audit, Risk and Governance Committees-in-Common would be held on Thursday 25 July 2024 at 9am to 12.30pm in the Boardroom, DPoWH and via MS Teams.

The meeting ended at 10am.